Know Your Benefits

ADP

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CIGNA

Employers Dental Services
A company of the Principal Financial Group

EyeMed Vision Care

DELTA DENTAL

MAGELLAN HEALTH SERVICES
Getting Better All the Time

Sedgwick CMS

TheStandard
Positively different

FY 2011-2012

Maricopa County Employee Benefit Plan

Envision living "well" into the future...

Version 1 ~ 10/21/11

Table of Contents

The information in this booklet highlights the Maricopa County Employee Benefits Program (the "Program") for benefit-eligible employees and their eligible dependents. The Program is managed by the Employee Benefits Division of the Business Strategies & Health Care Programs Department.

This booklet is intended to provide you with information needed to make informed decisions regarding the selection of your benefits provided by the Program. There is a Glossary of Terms and a Glossary of Acronyms provided for your reference to help you understand the information.

The benefits described herein are summaries of the County's official plan documents and contracts that govern the Program. In the event of a discrepancy between the information in this booklet and the official documents, the official documents govern.

Maricopa County reserves the right to change or cancel its Program, in whole or in part, at any time.

Participation in any of the County's benefit plans provided through the Program is not a contract of employment.

How to Obtain Benefit Information

Information about the Program is available on the Internet at **www.maricopa.gov/benefits** or on the Electronic Business Center (EBC)/ Intranet at **ebc.maricopa.gov/ehi**.

Both of these Web sites are referred to as the Employee Benefits Home page in this document.

You may also e-mail the EB Division at **BenefitsService@mail.maricopa.gov**, call 602-506-1010 from 8 AM to 5 PM MST Monday- Friday, or visit the EB Division located in the County Administration Building at 301 W. Jefferson St., Suite 3200, Phoenix.

The EB Division can assist you with general questions related to premiums, eligibility and enrollment, status changes, and benefit continuation while on or returning from a leave of absence (LOA) or upon retirement.

Please contact the specific benefit vendor for answers to detailed benefit questions regarding coverage, cost and claim(s) payment. Vendor contact information is located in the "**Who to Contact**" section of this booklet.

Important Information

Carefully Read All of the Information in this Booklet

Do not make a medical or dental election solely on the basis of a health care provider's participation with the vendor's provider network because physicians and dentists may stop participating during the plan year and you will not be allowed to change your plan election. If a specific physician or dentist is very important to you, consider selecting a plan with out-of-network benefits such as an Open Access Plus (OAP) High or Low medical plan or the Choice Fund PPO high-deductible medical plan and/or CIGNA Dental or Delta Dental plans. Plans with out-of-network benefits allow you to use providers who do not participate with the vendor's network, but you will incur higher out-of-pocket costs. Additionally, you should not make your pharmacy plan election on the basis of specific medications being on the preferred medication list because medication coverage status or tier level, as well as prior authorization or step-therapy requirements, may change during the plan year. For example, medications may change from preferred brand-name level to a generic or non-preferred brand-name level, or may become available over-the-counter and therefore would not be covered under the pharmacy benefit.

When enrolling via the online Benefit Enrollment System, make your election decisions carefully as once the enrollment period (30 calendar days from event date) expires, they cannot be changed until Open Enrollment and be effective the next plan year starting on July 1. Make sure to click the "Submit" button on the Benefit Summary page in the Benefit Enrollment System to finalize and save your elections. Once the "Thank You" page appears, your benefit enrollment is complete. To enroll, follow the instructions in the "**Enrollment Checklist**" section.

Print your "Confirmation Page" from the Benefit Enrollment System as verification of your elections. Keep this "Confirmation Page" to compare with the "Confirmation Statement" that will be mailed to your home address. Review your "Confirmation Statement" immediately and contact the EB Division within 10 business days from the print date of your "Confirmation Statement", if you discover an error between the two documents. Your printed "Confirmation Page" from the Benefit Enrollment System will be accepted as verification of your intended enrollment elections in the event of an error.

Some plans require an election of a Primary Care Physician (PCP) or Primary Care Dentist with your initial enrollment. Refer to the "**How to Look Up a Provider Online**" section.

Certain benefits require the use of your SSN. Refer to the "**Privacy**" section for more details.

Watch for your new ID cards in the mail and upon receipt, be sure to check the PCP or Dentist. Contact CIGNA or EDS to change your PCP or Dentist, if needed. If additional ID cards are needed, contact the vendor directly either by phone or through their Web site. See the "**Who to Contact**" section. Many vendors allow you to print a temporary ID card from their Web site once your enrollment information has been received from Maricopa County and processed by the vendor.

Glossary of Terms

Benefit-Eligible: A full- or part-time employee (not a temporary employee) of Maricopa County who is scheduled to work at least 20 hours per week. Contract employees may also be benefit-eligible based on the terms of their contract.

Biometric Screening Program: A program that provides employees with screenings for: Blood Pressure, Total/HDL Cholesterol and Ratio, Glucose, Height, Weight, Body Fat, Waist Circumference, and an individual Health Coaching Session that includes program referrals and health education on screening results.

Body Mass Index (BMI): A number calculated from a person's weight and height. The formula is defined as (weight in pounds*703)/(height in inches squared). For example, if your weight is 135 pounds and your height is 61 inches, your BMI is 25.50 (135*703))/(61*61).

CIGNA Care Network (CCN): A high-performing cost-effective specialty care provider network that includes the following provider specialties: Endocrinology, Allergy/Immunology, Ear/Nose/Throat, Cardiology, General Surgery, Dermatology, Gastroenterology, Hematology/Oncology, OB/GYN, Infectious Disease, Neurology, Nephrology, Ophthalmology, Orthopedics/ Surgery, Rheumatology, Cardio-Thoracic Surgery, Neurosurgery, Urology, Colon and Rectal Surgery and Vascular Surgery. These providers are identified by a 'Tree of Life' symbol in the CIGNA provider directory. You pay a lower copay when you receive care from a specialist who has earned the CCN designation. This designation is from January 1 to December 31st of each calendar year.

CMG (CIGNA Medical Group): A network of providers who are employed by CIGNA HealthCare of AZ who practice in the CMG Health Care Centers that are owned and operated by CIGNA. Primary and some specialty and ancillary care are provided at the CMG Centers. Some specialty care is provided through the OAP network when a referral is made by the CMG physician.

CMG High and Low Plan: Managed-care HMO plans that require members to use the CMG Health Care Centers for primary and most specialty and other ancillary services. Services provided by non-network providers or providers who practice in their own offices are not covered.

Co-insurance: A cost-sharing requirement under a health insurance policy, which provides that the insured will be liable for a percentage of the costs of covered services after payment of a deductible, if applicable.

Copay: A cost-sharing arrangement in which the insured pays a specified flat dollar amount for a specific service (such as $30 for an office visit). The amount does not vary with the cost of the service, unlike co-insurance, which is based on a percentage of the cost.

Deductible(s): The amount required to be paid by the insured before benefits become payable.

Flexible Spending Account (FSA): A plan which provides employees with a way to set aside money on a pre-taxed basis to cover the costs of either health care expenses that are not covered under their health insurance (medical, pharmacy, mental health, dental and vision) or dependent care expenses that enable the employee to work.

Group Insurance Qualified Status Change Form: A form provided by the Employee Benefits Division on which the employee reports specific qualified status changes. (Most status changes are reported online through the Benefit Enrollment System.)

Health Assessment (HA): A brief online questionnaire that analyzes the self-reported health risks of the employee.

Health Coaching Program: A program where Health Coaches work one-on-one with employees to help them identify and meet health improvement goals.

Health Maintenance Organization (HMO): HMOs offer comprehensive health coverage for both hospital and physician services. An HMO contracts with health care providers, (physicians, hospitals and other health professionals), who participate in their network. The enrollees of an HMO are required to use participating network providers for all health services, and many services must meet further approval by the HMO through its utilization review program. HMOs are the most restrictive form of managed care benefit plans because they manage and restrict the procedures, providers and benefits.

Health Plan: Includes medical, pharmacy, vision, behavioral health and substance abuse, and dental coverage.

Health Savings Account: A tax-exempt account established exclusively for the purpose of paying qualified medical expenses of the account beneficiary who, for the months for which contributions are made to an HSA, is covered under a high-deductible health plan.

High Option: A plan where premiums are higher than a low option plan because the insured shares less of the costs with lower copays.

In-Network (or Network, Participating Provider): Health care provided by a doctor, hospital, pharmacy or other health care provider with whom the health plan has contracted to provide services at specified fees.

Insured (aka Member): A person enrolled in and covered by an insurance policy.

Insurer (Insurance Company, carrier or vendor): A corporation, such as CIGNA HealthCare of Arizona, engaged primarily in the business of furnishing insurance to the public.

Low Option: A plan where premiums are reduced in comparison to a high option plan because the insured shares more of the costs in the form of higher copays and co-insurance.

Maximum Reimbursable Charge (MRC): A percentage that is based upon a methodology similar that utilized by Medicare to determine the allowable fee for the same or similar service within a geographic region. MRC only applies to out of network claims.

Note: The provider may bill the member the difference between the provider's normal charge and the Maximum Reimbursable Charge as determined by the benefit plan, in addition to applicable deductibles, copayments and co-insurance.

OAP (Open Access Plus) Plan: A plan that gives options to use a network or non-network provider each time the insured needs medical care, and does not require a referral to see a specialist.

OAPIN (Open Access Plus) In-Network: A plan that uses a network of providers who practice in their own offices, instead of in a medical group like the CIGNA Medical Group, and independently contract with CIGNA. Non-network providers are not covered under this plan. The OAP In-Network plan includes access to the CMG Health Care Centers. A referral is not required to see a specialist.

Out-of-Network (or Non-Participating, Non-Network Provider): Health care received from a provider who is not contracted with the insured's health plan network.

Out-of-Pocket Maximum: The maximum amount the insured pays each year for health care. The maximum may apply only to specific services such as inpatient hospitalizations. After this share of eligible expenses has reached the plan's out-of-pocket maximum per person or per family, the plan pays the full cost of eligible expenses for the rest of that plan year. Each summary plan description lists the expenses that count towards the out-of-pocket maximum.

Plan Year: July 1 through June 30.

Preferred Medication List (aka Formulary): List of prescription drugs approved by a pharmacy benefit manager. Drugs on the preferred medication list are generally more cost effective and are as effective as other drugs that are non-preferred in the same therapeutic medication class. The list is available on the Employee Benefits Home Page under the pharmacy tab and on the vendors Web sites.

Preventive Care Services: This includes all routine preventive services such as Well Baby Care, Well Child Care and Adult Preventive Care as identified by each plan in the plan summary in accordance with the U.S. Preventive Services Task Force recommendations.

Primary Care Physician (PCP): A physician who practices general medicine, family medicine, internal medicine or pediatrics.

Reasonable and Customary Charge (R&C): The prevailing charge of most other providers in the same or similar geographic area for the same or similar service. If the insured receives out-of-network services and the provider's fee is more than the R&C charge, the insured will have to pay the amount of charges above R&C. When care is received from an in-network provider, the eligible expenses are determined from the network provider's contracted rate.

Short-Term Disability (STD) Plan: STD pays a percentage of the insured's salary for up to 23 weeks after a 3-week waiting period if he/she becomes temporarily disabled due to sickness or injury and is not able to perform the essential functions of his/her job. The insured must be under the regular care and treatment of an appropriate provider.

Specialty Medication: Usually expensive drugs (oral or injectable) that are used to treat complex and rare medical conditions. These drugs may require special care and handling (such as refrigeration) and patient counseling due to their high risk of causing serious side effects or complications.

Sub-Acute Facilities: A hospital-based facility or a freestanding facility that provides lower level of care than acute care.

Term Life Insurance: Term life insurance covers a person for death benefits for a limited time (a term). In the case of the term life insurance coverage provided by The Standard, the term is conditional. You are covered as long as you are employed by Maricopa County. Term life insurance does not have any cash value.

Glossary of Acronyms

Abbreviations used throughout this booklet

AD&D: Accidental Death & Dismemberment

ADP: Automatic Data Processing, Inc.

AHCCCS: Arizona Health Care Cost Containment System

ARS: Arizona Revised Statutes

ASRS: Arizona State Retirement System

BMI: Body Mass Index

CCN: CIGNA Care Network

CMG: CIGNA Medical Group

COBRA: Consolidated Omnibus Budget Reconciliation Act

EAP: Employee Assistance Program

EB: Employee Benefits

EBAC: Employee Benefits Advisory Council

EBC: Electronic Business Center (Intranet)

EDS: Employers Dental Services

EE: Employee

EOI: Evidence of Insurability

FML: Family Medical Leave

FMLA: Family Medical Leave Act

FSA: Flexible Spending Account

HA: Health Assessment

HDL: High-density lipoprotein

HIPAA: Health Insurance Portability and Accountability Act

HMO: Health Maintenance Organization

HR: Human Resources

HSA: Health Savings Account

ID: Identification

IRC: Internal Revenue Code

IRS: Internal Revenue Service

LOA: Leave of Absence

MST: Mountain Standard Time

NAIC: National Association of Insurance Commissioners

NEO: New Employee Orientation

NP: Non-Preferred

NRS: Nationwide Retirement Solutions

OAP: Open Access Plus

OAPIN: Open Access Plus In-Network

OE: Open Enrollment

PCP: Primary Care Physician

PHI: Protected Health Information

PML: Preferred Medication List

PPO: Preferred Provider Organization

PRISM: Payroll, Records, Information, Staffing & Management (the Human Resources Integrated System)

PSPRS: Public Safety Personnel Retirement System

PST: Pacific Standard Time

RIF: Reduction in Force

Rx: Prescription

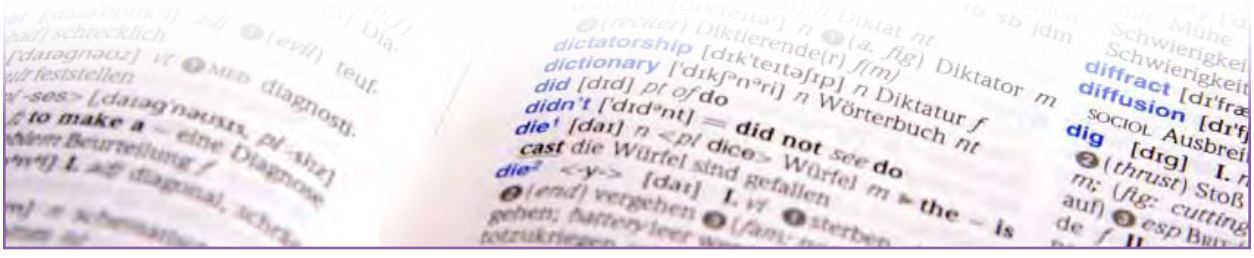
SCHIP: State Children's Health Insurance Program

SPD: Summary Plan Description

SSN: Social Security Number

STD: Short-Term Disability

UV: Ultraviolet



Introduction

Maricopa County recognizes your valuable contributions as an employee by offering comprehensive benefits for benefit-eligible employees and their eligible dependents through the Employee Benefits Program. Maricopa County is committed to helping you manage the high costs of health care, the risk of lost income due to illness and disability, and the need to prepare for a secure retirement. The County's program provides:

Health, Life, Disability Plans & Flexible Spending Accounts

- A choice of six medical plans;
- A choice of three pharmacy plans;
- A vision plan;
- A choice of two behavioral health and substance abuse plans;
- A choice of three dental plans;
- Basic and additional life plans, basic and additional accidental death and dismemberment plans, and dependents (spouse and child) life plans;
- A choice of three short-term disability (STD) plans; and
- Health care (general and limited use) and dependent care flexible spending accounts.

Other Programs, Plans and Voluntary Benefits Include:

- An employee assistance program (EAP);
- A financial counseling benefit;
- A deferred compensation plan;
- Discounts on auto, home and renter's insurance;
- A group legal plan;
- Arizona State Retirement System (ASRS) retirement plan, which include a long-term disability benefit, or Public Safety Personnel Retirement System retirement plan. If you meet the retirement system's eligibility criteria, you must be enrolled in and contribute to the applicable retirement plan.

Eligibility

Who's eligible?

You can participate in the health, life, and disability plans and the flexible spending accounts if you are a regular employee (except some contract employees as specified below) scheduled to work at least 20 hours per week.

For benefit plan purposes, "regular employee" is defined as a full-time or part-time employee who is not temporary, but who may be a contract employee. (When related to benefits administration, the definition herein of a regular employee differs from that which is used in the Merit Rules, available online at **http://ebc.maricopa.gov/pp/hr/tocs/EmpMerit_TOC.asp**.)

Employees working under specific contracts may or may not be eligible for benefits based on the terms of their contract. Contract employees may be offered health insurance benefits at the option of the appointing authority as long as the employee meets the same eligibility requirements of classified and unclassified employees. Contract employees scheduled to work less than 20 hours per week will not qualify for benefits, except in the following circumstance:

> Employees who retire from the ASRS are statutorily limited to the number of hours they may work for the first year following their retirement date. If one of these retirees returns to work within that time period, he/she may be offered only part-time benefits, regardless of the number of hours he/she is scheduled to work. This is at the option of the appointing authority, while the employee waits for the one year limitation on hours worked to expire. At that time, the employee shall revert to meeting the requirements of all other contract employees.

Regular employees who are scheduled to work less than 20 hours per week, all temporary employees, and contract employees whose contract specifies they are not benefit eligible are ineligible to participate in the health, life, disability plans, group legal plan and the flexible spending accounts.

Are dependents eligible?

Your legal spouse as defined or recognized by Arizona and federal law, including IRS regulations and rulings, (does not include same sex or common-law spouses, domestic partners, or significant others) and/or your child(ren) or your young adult up to age 26 (regardless of marital, student, residency or tax dependency status) or of any age if permanently and totally disabled prior to age 26 are eligible for coverage under your health plans and/or dependents life and family accidental death and dismemberment insurance plans.

The term "child or young adult" means your natural child, stepchild, legally adopted child, child placed with you for adoption or child for whom you have been awarded legal guardianship.

Verification of continued eligibility as a student or disabled child

You are responsible for ensuring that only eligible dependents are enrolled in your health plan and for immediately notifying the EB Division when your dependents become ineligible. You will be liable and responsible for the cost of all claims and administrative costs paid or incurred for your ineligible dependents beginning with the end of the pay period in which the dependents became ineligible. Additionally, failure to notify the EB Division within 60 calendar days of ineligibility forfeits the dependents' right to COBRA continuation coverage.

If your child is disabled and 19 or older, CIGNA will request verification of disability at frequencies determined by the type of disability.

Coverage and Enrollment

When does coverage begin for newly eligible employees?

You have 30 calendar days from your event date (date of hire for a newly hired employee, effective date of employee going from a benefit ineligible status to a benefit eligible status, or date of hire for an elected official) to select and submit your benefit elections online through the Benefit Enrollment System at **https://portal.adp.com**. To prevent a retroactive premium adjustment to your paycheck and to preserve your choice of benefits, online enrollment should be completed and submitted as soon as possible within the 30-day period. Refer to the "**Enrollment Worksheet Example**" and the "**Enrollment Checklist**" sections for details.

Premium starts accruing on the first day of the pay period that includes your coverage effective date and is not pro-rated.

New Hire or Rehire Status

Benefit coverage for a newly hired employee begins the first day of the month following the date of hire, except for FSA coverage, if the election is made after the first day of the month following the date of hire, coverage begins on the date the employee submits his/her elections. Life insurance becomes effective at different times depending on whether it is contributory (where the employer pays the premium) or non-contributory, if EOI is required, and if the application is made outside of the 30-day enrollment period. Benefit coverage for a re-hired employee with a break of employment of less than 30 calendar days begins the first day of the pay period following benefit termination, so that there is no gap in coverage.

Benefit Ineligible to Benefit Eligible Status

Benefit coverage for an employee whose change in employment status renders him/her benefit eligible, such as going from temporary status to regular status, begins the first day of the month following the status change, except for FSA coverage, if such election is made after the first day of the month following the status change, coverage begins on the date the employee submits his/her elections. Life insurance becomes effective at different times depending on whether it is contributory (where the employer pays the premium) or non-contributory, if EOI is required, and if the application is made outside of the 30-day enrollment period.

Automatic Enrollment

If you do not complete enrollment online through the Benefit Enrollment System within 30 calendar days of your newly eligible or new hire or rehire date, you will be automatically enrolled in the CIGNA Open Access Plus Low option medical plan, the Consumer Choice pharmacy, vision and behavioral health plans for employee only coverage. Your basic life insurance coverage will be one times your annual salary rounded up to the next thousand to a maximum of $500,000. Your coverage will be effective as explained in the "**New Hire or Rehire**" or "**Benefit Ineligible to Benefit Eligible Status**" sub-sections above. However, if you were employed by Maricopa County, terminated employment and then were re-hired within 30 calendar days, the benefit elections in place before your termination will be reinstated, with no option of changing your elections.

You can "opt out" of medical coverage by completing enrollment within the aforementioned 30-day period and changing the automatic enrollment election to "Waive". If you fail to do this, you will be enrolled in the aforementioned benefit plans for the entire plan year and the applicable benefit premium deductions, with no Wellness premium reductions, will be taken out of your paycheck. These elections are irrevocable until the next plan year.

Can I change my benefits once I've submitted my benefit elections in the Benefit Enrollment System?

For new hire or newly eligible events, you may change your benefits during the enrollment period (30 calendar days from event date). Once the enrollment period expires, changes to your benefit elections or to the automatic enrollment will not be allowed until the next Open Enrollment period.

Decreases to additional life insurance, additional AD&D and dependents life insurance are allowed at any time. Application for increases to additional life insurance may be made at any time, as long as EOI is provided, but the increase is subject to the approval by the life insurance company.

Open Enrollment occurs at times designated by the EB Division. The next open enrollment will be April, 2012 with benefit elections being effective on July 1, 2012. Open Enrollment dates are posted in advance on the EBC Intranet and communicated to each department via EBC **EBC Headlines** and emails sent to the department's representative to the Employee Benefits Advisory Council. Additionally, an Open Enrollment Worksheet will be mailed to your home address prior to the beginning of the next Open Enrollment period, providing you with enrollment details.

If you have a qualified status change as defined under the IRC Section 125 during the plan year, certain changes are allowed. These are explained in the "**When Can Changes be Made & When Are They Effective?**" section and "**What is a qualified status change?**" sub-section.

Waiving Insurance Coverage

Waiving the Medical Insurance Package

If you do not wish to enroll in coverage under the County's medical insurance package, you must waive (decline) coverage under the County's plan by submitting your request within the enrollment period via the Benefit Enrollment System. Failure to submit your request to waive coverage during your new hire/newly eligible enrollment period will result in automatic enrollment as explained in the "**Automatic Enrollment**" sub-section above. Refer to the "**Important Information**" section regarding the time limitation for correction of enrollment errors.

If you elect to waive the medical insurance coverage, you relinquish County medical package coverage during the current plan year, which includes medical, behavioral health, substance abuse, vision, wellness and pharmacy benefits. However, Maricopa County offers a stand-alone vision plan, dental plans, EAP and/or additional life insurance to employees who elect to waive the medical insurance package.

Waiving Other Insurance Coverage When Newly Eligible

You may elect to waive any or all of the following when you are newly eligible. However, enrollment into the plans following your initial eligibility date is limited.

Short-term Disability: You must wait until the next scheduled Open Enrollment to elect coverage regardless if you have a qualified status change.

Dental Insurance: You must wait until the next scheduled Open Enrollment period to elect coverage, unless you experience a qualified status change that is consistent with the need for dental coverage and you enroll during the enrollment period. Refer to "**What Coverage Changes Can I Make During the Plan Year?**" section.

Additional Life: You may elect this coverage up to the Guarantee Issue Amount (GIA) without providing EOI, if you experience a qualified status change and you enroll during the enrollment period. Additionally, you may increase your coverage by one level up to the GIA during Open Enrollment without providing EOI. You may also apply for this coverage at any time during the plan year, but EOI will be required. See "**Additional Life and Additional Accidental Death and Dismemberment (AD&D) Insurance**" sub-section in the "**Life Insurance Plan**" section for details regarding EOI requirements.

Dependents Life: You may elect this coverage up to the GIA without providing EOI, if you experience a qualified status change and you enroll during the enrollment period. You may also apply for this coverage at any time during the plan year, but EOI will be required. See "**Dependents (Child and Spouse) Life Coverage**" sub-section in the "**Life Insurance Plan**" section for details regarding EOI requirements.

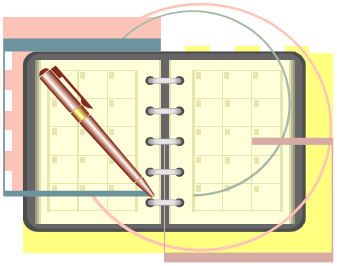
Flexible Spending Accounts: You must wait until the next scheduled Open Enrollment to elect coverage, unless you experience a qualified status change and you enroll during the enrollment period. You may revoke your old election and make a new election, provided that both the revocation and new election are because of and correspond with the change in status. As a general rule, an election change will be found to be consistent with a change in status event if the event affects eligibility for coverage under the plan. A change in status affects eligibility for coverage if it results in an increase or decrease in the number of dependents who may benefit under the plan. In addition, you must also satisfy the following specific requirements in order to alter your election based on the change in status:

- **Gain of Coverage Eligibility under Another Employer's Plan**
  For a change in status in which you, your spouse, or your dependent gain eligibility for coverage under another employer's benefit plan as a result of a change in your marital status or a change in your, your spouse's or your dependent's employment status, your election to cease or decrease coverage for that individual under the plan would correspond with that change in status only if coverage for that individual becomes effective or is increased under the other employer's plan.
- **Dependent Care FSA**
  You may change or terminate your election only if (1) such change or termination is made because of and corresponds with a change in status that affects eligibility for coverage under the plan; or (2) your election change is because of and corresponds with a change in status that affects the eligibility of dependent care assistance expenses for the available tax exclusion.

  Example: Employee Mike is married to Sharon, and they have a 12 year-old daughter. The employer's plan offers a dependent care FSA plan as part of its Program. Mike elects to reduce his salary by $2,000 during the plan year to fund dependent care coverage for his daughter. In the middle of the plan year when the daughter turns 13 years old, however, she is no longer eligible to participate in the dependent care FSA. This event constitutes a change in status. Mike's election to cancel coverage under the dependent care program would be consistent with this change in status.

Refer to the "**What Coverage Changes Can I Make During the Plan Year?**" section.

How To Enroll When You're Newly Eligible



You should attend a New Employee Orientation (NEO) meeting to receive Program information. You must complete your enrollment within 30 calendar days of your new hire or newly eligible event date online through the Benefit Enrollment System accessed through **https://portal.adp.com**. Instructions for online enrollment are provided in the "**Enrollment Checklist**" section. It is in your best interest to complete and submit your online enrollment as soon as possible. If you are not scheduled to attend an NEO meeting, you have the following additional options:

1. Ask your department's HR Liaison for enrollment information.
2. Go online to the EB Home page to obtain the benefit plan information you need to make your choices.
   a. The EBC Intranet address is: **http://ebc.maricopa.gov/ehi**
   b. The Internet address is: **http://www.maricopa.gov/benefits**
3. Contact the EB Division via Outlook e-mail at **BenefitsService@mail.maricopa.gov**.
4. Call the EB Division for information at 602-506-1010, press 2 and then 2 again.
5. Visit the EB Division at 301 W. Jefferson St., Suite 3200, Phoenix, AZ 85003.

Who Pays For Benefit Coverage?

Employer Contribution

Maricopa County makes a generous contribution toward the cost of your medical, pharmacy, vision, behavioral health and dental plans, and pays 100% of the cost of your basic life and accidental death and dismemberment plans and the Employee Assistance Program. You have the option of selecting medical coverage from CIGNA, pharmacy coverage from Catalyst Rx (except for the Choice Fund medical plan that has pharmacy coverage through CIGNA), and dental coverage from: Employers Dental Services (EDS), Delta Dental or CIGNA Dental. If you are a regular employee scheduled to work 30 or more hours per week or a contract employee with full-time benefits, you receive the maximum Maricopa County contribution toward the total premium (your cost) for the medical package (medical, vision, pharmacy, and behavioral health) and for either the Delta or CIGNA dental plan for you and your eligible dependents. You pay the "Full-time Employee Premium".

If you are a regular employee scheduled to work 20 to 29.99 hours per week or a contract employee with part-time benefits, you receive a lower Maricopa County contribution toward the total premium for the medical package and for either the Delta or CIGNA dental plan for you and your eligible dependents. You pay the "Part-time Employee Premium".

If you are a regular employee scheduled to work at least 20 hours per week or a contract employee with benefits, the County contributes the same amount toward the total premium for the EDS dental plan.

Note: It is the department's responsibility to ensure that the employee's job record in PRISM displays the appropriate number of scheduled hours and that applicable time is reported for payroll processing each pay period, even if the employee is on an unpaid leave of absence, in order for the employee premium and employer contributions to be calculated and paid or deducted correctly.

Employee Contribution

Deductions for the medical package (medical, vision, pharmacy, and behavioral health), dental and health care and/or dependent care FSAs reduce your taxable income, thus saving you money that would otherwise be paid in taxes. This tax advantage is provided under and follows the provisions of IRC Section 125.

When you elect benefits initially and during Open Enrollment (including passive Open Enrollments), you authorize the County to deduct the current employee benefit premiums or contributions from your paycheck for each benefit plan you elect (except for flexible spending accounts). Benefit-related payroll deductions will be made based on the first two pay period end dates of each month, generally 24 times per plan year. This means that there will be two pay periods during the plan year where benefit premiums are not deducted. This occurs when there are three pay period end dates in a month.

Please note that some benefits have payroll deductions 26 times per plan year. These include flexible spending accounts, employee contributions to their health savings account (associated with the CIGNA Choice Fund medical plan), auto, home and renter's insurance, financial counseling, and if you have a balance in arrears for any past due benefit payments. In these instances, deductions are taken every pay period.

You are responsible for reviewing your paycheck to verify that the correct premium deduction amounts are taken for the benefit plans you elected and the correct wellness premium reductions are given for the initiatives for which you participated. Please refer to the "Per Pay Period Premiums" tables in the applicable benefit section for each benefit elected and compare these rates to the deductions on your paycheck.

If the premium deductions and/or premium reductions on your paycheck are incorrect in that you have been charged a higher amount due to an error, and you identify the problem in writing to the EB Division within six months from the date the error began, your premiums and/or premium reductions will be adjusted retroactively to reflect the correct amounts. Incorrect premium deductions resulting from you not notifying the EB Division within 30 calendar days to remove an ineligible dependent will not be refunded to you until a full claims audit has been conducted to determine your liability. Errors discovered after six months from the date the error began will be corrected on a prospective basis with no refund on the overpaid premium or premium reduction.

Regardless of when an error is discovered, if your premium deduction is incorrect in that you have been charged a lower amount than you should have paid, your premiums will be adjusted retroactively to the date of the occurrence and you will be responsible for the cost of the underpaid premiums.

When Does Coverage End?

Coverage ends the last day of the pay period in which you and/or your covered dependents cease to be eligible (for example, if an employee terminates or retires in the middle of a pay period, or an elected official's term ends mid-pay-period, coverage would end at midnight of the last day of that pay period). However, in the case of death, coverage ends the day following the date of death.

You are responsible for notifying the EB Division within 30 calendar days when a dependent is no longer eligible. Refer to the "**Are dependents eligible?**" sub-section for details. **When coverage ends, you are liable and responsible for the cost of all claims and administrative costs incurred by you and your dependents and paid by the plans after the last day of coverage. Additionally, you and/or your dependents will lose eligibility to continue coverage under COBRA if notice of ineligibility is not received within 60 calendar days of the event.**

If you and/or your covered dependent(s) ceases to be eligible for the medical package (including medical, pharmacy, vision and behavioral health), dental insurance or the Health Care FSA and you notify the EB Division of such ineligibility within 60 calendar days of the event, a COBRA notice containing enrollment and premium information will be mailed to you and/or your dependent at your home address on file in the PRISM system. By enrolling in COBRA coverage within the allowed time frame and paying the total monthly premium and administrative charge, coverage for medical, pharmacy, vision and behavioral health, dental, vision only, and/or health care FSA will continue retroactive to your coverage end date without a break in coverage and continue through the period of COBRA eligibility. Refer to the "**Notifications**" section for additional information.

When and How Can Changes Be Made & When Are They Effective?

General

If you experience a qualified status change during the plan year, you may be eligible to add dependents to or drop dependents from your current benefit plans, but you cannot change your current benefit plans. The list of events that constitute a qualified status change is provided in the "What is a qualified status change" sub-section below.

Qualified status changes must be verified through supporting documentation and must be consistent with the event as defined under IRC § 125. Benefit election changes are consistent with status changes only if the election changes are necessary or appropriate because of the status change.

Most qualified status changes must be completed online through the Benefit Enrollment System within 30 calendar days of the change (except for number 6 and 7 listed in the sub-section below where the completion period is 60 days). Exceptions to the online process include: 1) status changes regarding ineligible dependents that were not reported within 30 days of ineligibility must be submitted on a "Group Insurance Qualified Status Change" form and provided to the EB Division, and 2) status changes regarding revocation or reinstatement of benefits due to a leave of absence must be submitted on a "Group Insurance Qualified Status Change" form within 30 calendar days of the change.

Supporting documentation regarding the status change will be requested through the Dependent Verification Services division of ADP. Failure to respond to or provide sufficient documentation to Dependent Verification Services will result in retroactive termination of coverage and liability for any services received.

What is a qualified status change?

Qualified status changes are occurrences that cause either a gain or loss of eligibility. Examples of qualified status changes, as permitted by IRC Section 125, are listed below:

1. Change in status:
   a. Events that change an employee's legal marital status, including the following: marriage, death of spouse, divorce, legal separation, or annulment;
   b. Events that change an employee's number of dependents, including the following: birth, death, adoption, and placement for adoption. In the case of the Dependent Care FSA, a change in the age of the qualifying individual (e.g. child turns 13).
   c. Any of the following events that change the employment status of the employee, the employee's spouse or the employee's dependent:
      - termination or commencement of employment;
      - strike or lockout;
      - commencement of or return from an unpaid leave of absence (LOA) including FMLA;
      - change in residence or work site where eligibility no longer exists for the plan originally selected or where the employee or dependent becomes eligible in the new residence or work site;
      - change in the number of regularly scheduled hours to become benefit eligible or ineligible;
      - change in job or employment status that renders the employee benefit eligible or ineligible, such as moving from temporary status (benefit ineligible) to a benefit-eligible status, or changing from a contract position with no benefits to a position with benefits.

2. Dependent satisfies or ceases to satisfy eligibility requirements such as attainment of age;
3. Judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody, including a qualified medical child support order requiring accident or health coverage for an employee's child;
4. Significant cost change of a benefit plan for an employee (mid-plan year change) or the spouse's plan (mid-plan year or plan year change), or coverage under a benefit plan for an employee (mid-plan year change) or the spouse's plan (mid-plan year or plan year) is significantly curtailed or ceases.
5. Entitlement for Medicare or Medicaid (the Arizona Health Care Cost Containment System) more commonly referred to by its acronym AHCCCS, the Medicaid program in Arizona.
6. Medicaid or State Children's Health Insurance Program (SCHIP) coverage is terminated as a result of loss of eligibility.
7. Entitlement for a state premium assistance subsidy under the plan from Medicaid or SCHIP.

Effective Date of the Change

Below are the qualified status changes and when the change becomes effective. For STD and life insurance, review the last two paragraphs of this sub-section.

Adding dependents, electing benefits if previously waived, or waiving benefits - due to birth, adoption, and placement for adoption

Employees may add a new dependent, waive benefits if currently enrolled, or enroll if currently waiving benefits, when a qualified status change occurs due to birth, adoption or placement for adoption. The coverage effective date is the date of the event (date of birth, date of adoption, or date of placement for adoption). Premium changes associated with the qualified status change become effective the pay period in which the new coverage is effective.

In accordance with ARS 20-1057 B, if your medical coverage is under a CIGNA CMG or OAP plan, coverage of a newborn child, a child placed for adoption or an adopted child is effective from the date of birth or placement and will continue for the following 30 calendar days. There is no premium associated with coverage for the first 30 days as long as you do not enroll the child for ongoing coverage. In order for medical coverage to continue past the initial 30 days, you are required to enroll the child online through the Benefit Enrollment System within 30 calendar days of the event and paying a premium retroactively to the date of the event if you are not currently in the appropriate coverage premium level (i.e., if you are paying the employee-only or employee-and-spouse premium instead of the employee and family or employee and child premium).

Adding or dropping dependents, electing benefits if previously waived, or waiving benefits - due to all other status change events (marriage, dependent attains or loses eligibility, court orders, legal guardianship, etc. except return from military leave.)

Employees may add newly acquired or newly eligible dependents or drop covered dependents, waive benefits if currently enrolled, or enroll if currently waiving benefits, when a status change occurs other than birth, adoption or placement for adoption. When adding or dropping a dependent, the coverage effective date or the coverage termination date is prospective and is the date the change is entered online in the Benefit Enrollment System. Premium changes associated with the qualified status change become effective the pay period in which the new coverage or termination is effective.

Return from Military Leave

The coverage effective date for employees returning from military leave is the date they return to work.

Losing Eligibility – all status change events

When a dependent ceases to meet the definition of an eligible dependent, that dependent must be terminated from coverage. The dependent's coverage ends the last day of the pay period during which he/she lost eligibility. However, in the case of death, coverage ends the day following the date of death.

Short Term Disability (STD)

If you elect STD when you first became benefit eligible or during Open Enrollment, you may not change your election until the next Open Enrollment, even if you have a qualified status change. The only exceptions that may apply are if you are subject to a Reduction in Force (see HR2403) or are called to active military duty. In these cases, you are ineligible to receive STD payments and are therefore required to drop coverage.

Life insurance

If you elected Additional Life insurance and/or Dependents Life insurance, you have special rules that apply. These plans are not subject to IRC Section 125. Please see the special rules that apply to these life insurance plans, in the "**Life Insurance Plan**" section.

What Changes Can I Make During The Plan Year?

Generally, your pre-tax benefit elections made either when newly eligible or during Open Enrollment are irrevocable during the plan year. However, when you have a qualified status change, you can add dependents to or drop dependents from your plans provided that the action is consistent with the status change. At any time during the plan year, changes can be made to After-Tax benefits, except for the Short-Term Disability plan and Group Legal.

Note: If an employee is covered under the group health plan of his/her spouse's employer and wants to voluntarily drop coverage during its Open Enrollment period and enroll in a County-sponsored medical plan, and the spouse's employer has a different plan year, this is not considered a qualified status change. An individual is entitled to enroll in a County-sponsored plan only if he/she loses eligibility. Because the employee would remain eligible for coverage under the other plan, the employee's decision to voluntarily drop coverage under his/her spouse's plan would not be a loss of coverage. The employee would need to wait until the next County Open Enrollment period to enroll in a County-sponsored plan. The spouse's employer may allow a midyear drop in coverage due to enrollment in another plan although the County's plan does not.

Provided below is a list of changes that you can make either to your coverage or benefit record. Some changes can be initiated by the employee through the Benefit Enrollment System [Employee Self Service (ESS)], others are system-generated events based on changes to your Job Record, and others are events controlled by the Employee Benefit Division in their role as Administrator.

Birth, Adoption, Placement for Adoption or Legal Guardianship Event (ESS)

- Add or drop coverage for your child, or legal guardian
- Drop coverage for your spouse, step-child or legal guardian
- If employee does not have coverage, elect coverage for the medical package[1], dental, life[2], FSA, and Group Legal
- If employee has coverage, waive coverage for the medical package[1], dental, life[2], FSA, and Group Legal; change the plan option for vision; or increase or decrease coverage for life[2] and FSA

Marriage Event (ESS)

- Add or drop coverage for your spouse, child, step-child or legal guardian
- If employee does not have coverage, elect coverage for the medical package[1], dental, life[2], FSA, and Group Legal
- If employee has coverage, waive coverage for the medical package[1], dental, life[2], FSA, and Group Legal; change the plan option for vision; or increase or decrease coverage for life[2] and FSA

Divorce/Annulment or Legal Separation Event (ESS)

- Add coverage for your child
- Drop coverage for your spouse, child, step child and legal guardian
- If employee does not have coverage, elect coverage for the medical package[1], dental, life[2] (but not spouse life), FSA, and Group Legal
- If employee has coverage, waive coverage for the medical package[1], dental, life[2], FSA, and Group Legal; change the plan option for vision; or increase or decrease coverage for life[2] (but not spouse life) and FSA

Dependent Gains Other Coverage Event (ESS)

- Drop coverage for your spouse, child, step-child or legal guardian
- If the employee does not have coverage, elect coverage for life[2] and Group Legal
- If the employee does have coverage, waive coverage for the medical package[1], dental, life[2], FSA, and Group Legal; change the plan option for vision; or increase or decrease coverage for life[2] and FSA

Dependent Loses Other Coverage Event (ESS)

- Add coverage for your spouse, child, step-child or legal guardian
- If the employee does not have coverage, elect coverage for the medical package[1], dental, life[2], FSA, and Group Legal
- If the employee does have coverage, change plan option for vision; waive coverage for life[2], FSA and Group Legal; or increase of decrease coverage for life[2], and FSA

Dependent Becomes Eligible (ESS)

- Add coverage for your child, step-child or legal guardian
- If the employee does not have coverage, elect coverage for Child Life[2], FSA and Group Legal
- If the employee does have coverage, waive coverage for FSA and Group Legal; increase coverage for Child Life[2]; increase or decrease coverage for FSA

Dependent No Longer Eligible (ESS)

- Drop coverage for your child, step-child or legal guardian
- If the employee does not have coverage, elect coverage for Group Legal
- If the employee does have coverage, waive coverage for Child Life[2], FSA and Group Legal; or decrease coverage for FSA

Update Dependent Information Event (ESS)

- Update demographic information (name, gender, SSN, HICN, date of birth, relationship type, student flag or disabled flag for all dependents; address for beneficiaries) for your spouse, child, step-child, legal guardian, and beneficiary
- Add or delete beneficiaries

Change After Tax Benefits Event (ESS)

- If the employee does not have coverage, elect coverage for Additional life[2], Additional AD&D, Child life[2], and/or Spouse life[2]
- If the employee does have coverage, waive, increase or decrease coverage for Additional life[2],Additional AD&D, Child life[2], and/or Spouse life[2]

Change in Dependent Care Cost Event (ESS)

- If the employee has coverage, waive, increase or decrease coverage for Dependent Care FSA

Beneficiary Information Update Event (ESS)

- Add or delete beneficiaries
- Update demographic information (name, gender, SSN, date of birth, relationship type, and address) for existing beneficiaries

Change HSA Contribution or Catch-up Contribution Event (ESS)

- Elect, waive, increase or decrease the contribution to the Health Savings Account

Retiree to Active Event (System Generated)

- Add or drop coverage for your spouse, child, step-child or legal guardian
- If employee does not have coverage, elect coverage for the medical package[1], dental, life[2], STD, FSA, and Group Legal
- If employee has coverage, waive coverage for the medical package[1], dental, life[2], STD, FSA, and Group Legal; change the plan the medical package[1] and dental coverage; or increase or decrease coverage for life[2] , STD, and FSA

Newly Eligible Event (System Generated)

- Add or drop coverage for your spouse, child, step-child or legal guardian
- Elect coverage for the medical package[1], dental, life[2], STD, FSA, and Group Legal

Data Related Eligibility Change Event (System Generated)

- The processing rules are variable, depending on the type of eligibility change, such as loss of eligibility for current option or gain of eligibility for current option. The Benefit Enrollment System determines which benefit(s) can be changed for this event and sends ESS the data needed to open certain benefit areas for enrollment.

Change in EOI Status Event (Administrator)

- If the employee does not have coverage, elect coverage for life[2]
- If the employee does have coverage, waive, increase or decrease coverage for life[2]

Add or Remove Court Ordered Dependent Event (Administrator)

- Add or drop coverage for your court-ordered dependent
- If the employee does not have coverage, elect coverage for the medical package[1], dental, life[2], FSA and Group Legal
- If the employee does have coverage, change the plan option for the medical package[1] and dental coverage; waive coverage for Group Legal, and waive, increase or decrease coverage for life[2], and FSA

Death of Spouse Event (Administrator)

- Add coverage for your child
- Drop coverage for your spouse, child, step-child or legal guardian
- If the employee does not have coverage, elect coverage for the medical package[1], dental, life[2] (except Spouse Life), FSA and Group Legal
- If the employee does have coverage, waive coverage for the medical package[1], dental, life[2], FSA and Group Legal; change plan options for vision coverage; increase or decrease coverage for life[2] (except Spouse Life), and FSA

Death of Child Event (Administrator)

- Drop coverage for your child, step-child or legal guardian
- If employee does not have coverage, elect coverage for Group Legal
- If employee does have coverage, waive coverage for Group Legal, or waive, or increase or decrease coverage for life[2], and FSA

Footnotes:

[1]The Medical package means medical, pharmacy, vision and behavioral health coverage

[2]Changes and/or increases to life insurance is subject to Evidence of Insurability rules

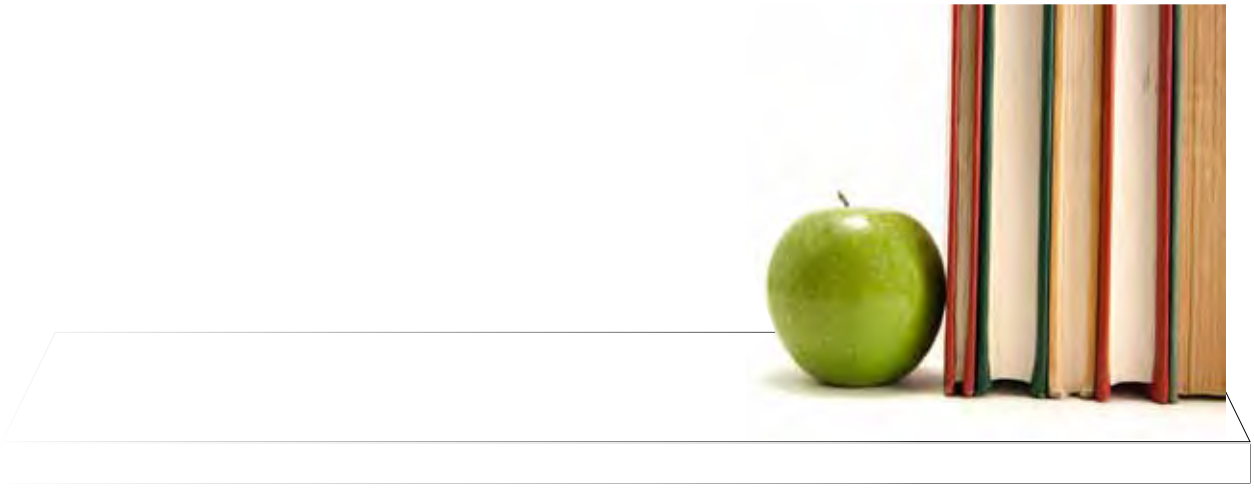
What Documentation is Required for Qualified Status Changes?

Documentation of your qualified status change is required and will be requested by letter from Dependent Verification Services. Refer to "**When and How Can Changes Be Made and When Are They Effective?**" section, "**General**" sub-section.

Documentation for adding a spouse includes: a redacted joint tax return or a marriage certificate and one of the following: joint bank or credit account, joint deed, mortgage or lease agreement, joint obligors on a loan, joint ownership or lease of a motor vehicle, or joint utility bill of mutual residence. Multiple proofs are required for spouses to verify that the employee and spouse are married and currently living together.

Documentation for adding a child includes: birth or adoption certificate, qualified medical child support order, official court documentation, or current tax return.

Documentation for dropping a spouse or child depends on the reason for the status change and includes: divorce decree or court order, death certificate, or document from the dependent's employer.



Privacy

HIPAA Privacy Notice

In accordance with the privacy standards contained in the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Maricopa County, in its role as the administrator and/or sponsor of the Program, or in its role as the health plan, makes available a notice through the EBC Intranet at **http://ebc.maricopa.gov/ehi** EB Home page setting forth its privacy practices. This notice describes the potential uses and disclosures of Protected Health Information (PHI), the individual's rights and the plan's legal duties with respect to PHI. The privacy notice may be updated occasionally and such updates are communicated through Benefit Headlines on the EBC Intranet.

Sharing Your Protected Health Information

You and your dependents' PHI will be shared with specific benefit plan representatives and others for the purposes of your health care treatment, payment for that treatment and health care operations (as defined in the HIPAA of 1996, as amended) of Maricopa County and of the benefit plan vendors, as well as for other purposes allowed or required by law.

Employee Certification

By submitting your benefit choices or allowing automatic enrollment of your benefit elections or your current benefits to roll over, you authorize Maricopa County to take deductions from your paycheck to pay for your benefit costs. You also authorize the Employee Benefits Division to send necessary personal information to your selected vendors to initiate and support your coverage. You further certify that you have reviewed the instructions provided in the Benefits Enrollment System and the applicable benefit plan information provided via the Employee Benefits Home page and that you take full responsibility for you benefit elections. You understand that your benefit elections are irrevocable after the close of the enrollment period.

By submitting your enrollment request or continuing with your current health care coverage, you understand and agree that Maricopa County may share PHI concerning you and your dependents, as described in the Maricopa County Notice of Privacy Practices, with your health care providers which could include CIGNA HealthCare of AZ and CIGNA Dental, Catalyst Rx, Magellan Health Services, Delta Dental, Employers Dental Services, The Standard Life, EyeMed Vision Care, and Sedgwick CMS. You further agree to release Maricopa County and Maricopa County's health care providers from any liability for any good faith release of PHI in connection with your benefits or as otherwise authorized or required by law.

By updating and/or submitting your elections through the Benefit Enrollment System, you understand that you are making an electronic signature in accordance with applicable state and/or federal law. This signature is the equivalent of a manual signature.

By submitting your elections, you certify, to the best of your knowledge, all information you have provided is accurate, correct and complete. You understand that you may be subject to disciplinary action up to and including termination for failing to provide accurate and complete information. You further understand and agree that you will be required to reimburse Maricopa County for any additional premiums and/or the full cost of claims and administrative expenses paid as a result of providing inaccurate, incorrect and/or incomplete information.

Notice Regarding Use of Your Social Security Number or Health Insurance Claim Number

Disclosure of your Social Security Number (SSN), and your Health Insurance Claim Number (HICN) if enrolled in Medicare, for purposes of enrollment and other benefit-related issues is voluntary except when required under Section 111 of Public Law 108-173 (Medicare Secondary Payer Mandatory Insurer Reporting Requirements Act).

ID numbers on the identification (ID) cards from each benefit vendor vary and will carry either no ID number, an edited ID number (revealing only the last four digits of your SSN), your employee ID number, or a random system-generated number.

Your SSN is transmitted to the benefit plan vendors for administrative purposes. Some vendors will use your SSN as your ID number or cross-reference the assigned ID number to your SSN.

If you do not want your SSN transmitted to the benefit plan vendors and you are not required under the aforementioned Public Law to provide your SSN, you may request an Alternative ID number.

If you are participating in the flexible spending account plan, group legal plan, or the Choice Fund high-deductible medical plan, the vendor requires your SSN. If you do not want your SSN sent to the flexible spending account, group legal plan or in the case of Choice Fund, all benefit plan vendors, you should not enroll in these benefits.

Alternative ID Number

You may request an Alternative ID number to be used in lieu of using your SSN, except as specified above, by completing the Alternative ID Request form available on the EB Home page, or by sending your request in writing to the EB Division. You will be provided with a form to complete before the Alternative ID number can be assigned.

If you are completing your initial benefits enrollment and you do not want your SSN sent to the vendors, you should not complete your enrollment online. Request assistance from the EB Division before the end of your enrollment period. Your enrollment (but not your benefit coverage effective date) in benefits will be delayed until the Alternative ID number is assigned.

Once assigned, the EB Division will provide you with your Alternative ID number and notify your medical, pharmacy, vision, behavioral health and dental vendors of your Alternative ID. Once the vendor links your enrollment to an Alternative ID number, you and your dependents will not be identifiable by your SSN. You are responsible for advising each provider that you have an Alternative ID number and that they must use that number instead of your SSN when filing claims or requesting eligibility information or authorizations for services.

You should be aware of the following possible consequences of having an Alternate ID number assigned:

- If the vendor uses a system-generated ID number, your Alternative ID number will be cross-referenced to the system-generated ID number. When you access services, your provider will verify your current eligibility by calling the vendor. The provider must use either your current Alternative ID number or your system-generated ID number so that your eligibility can be established, you can access services and your claims can be processed and paid.
- Additionally, when an Alternative ID number is assigned, if you have ever been identified by your SSN, some vendors do not have the technology to cross-reference your records to re-establish prior authorizations or referrals for your care or to process claims submitted under your SSN because the key link between you and their records (your SSN) has been broken. This may cause a temporary delay in receipt of services or result in denied claims until you notify the vendor to correct the records.

Choosing The Plan That Suits You

Maricopa County is committed to promoting better health for its employees and their families by continually evaluating our employee health benefits. Furthermore, Maricopa County continually looks for innovative solutions that will help effectively control short- and long-term health care costs without sacrificing the quality of health care. By providing a wide selection of medical benefit plan options, every employee has the opportunity to choose the 'right plan".

To help you decide what medical plan is "right for you", read and answer the following questions. Table A is specific to the Choice Fund High Deductible Health Plan medical plan that has a Health Savings Account, and Table B applies to all other medical plan options.

Table A

Is the Choice Fund Medical Plan with Health Savings Account Right for You?	*Yes*	*No*
Are you interested in getting a free medical plan ($0 payroll deduction for employee or family coverage?)* **For non-tobacco users with completed Biometric Screening and Health Assessment*	☐	☐
Would you like to get free preventive care and free preventive medication without having to meet a deductible?	☐	☐
Are you interested in getting an annual tax-free contribution* by the County to your own Health Savings Account? **Receive up to a $500 individual or $1,000 family contribution annually. Amount is prorated by number of months enrolled during the plan year.*	☐	☐
Do you take an active role in managing your health care and health care costs?	☐	☐
Is it important to have the freedom to go to any primary care physician or specialist you choose and have direct access to specialists without getting referrals?	☐	☐
Do you want to own a health savings account where the unused balance rolls over each year and that you can take with you when you leave employment with the County?	☐	☐
Do you enjoy managing and investing your money in programs like Deferred Compensation or other investment vehicles and watching your balance grow over the years?	☐	☐
Are you interested in having money available to help save for future medical and retiree health expenses on a tax-free basis?	☐	☐

If you answered 'Yes' more than twice, please turn to the Medical Plan Summary Chart and review information on the Choice Fund medical plan benefit option.

Table B

Find the medical plan that's BEST FOR YOU!	Applicable Plans
Q: Will you and/or your covered dependents live outside of Maricopa County during the plan year? **A:** The OAP High and Low and the Choice Fund medical plans offer out-of-network benefits and national networks of providers. The OAP In-Network option uses a national network of providers but does not offer out-of-network benefits.	OAPIN OAP High OAP Low Choice Fund
Q: Do you like to use the CIGNA Health Care Centers exclusively for your primary care and most of your specialty care? **A:** If you enjoy the convenience of receiving your primary medical care through a CIGNA Health Care Center (owned and operated by CIGNA), you may want to consider the CMG High or Low benefit options.	CMG High CMG Low
Q: Do you prefer lower out-of-pocket costs (copays and co-insurance) when deciding which medical benefit option to choose? **A:** Lower out-of-pocket costs, such as copays, mean that your per paycheck deduction will be higher than other plans. CMG High and OAP In-network benefit options offer the lowest copays.	CMG High OAPIN
Q: Are your doctors and hospitals covered under the medical benefit option you choose? **A:** For all benefit options, CIGNA contracts with a variety of medical providers for different services that includes doctors, hospitals, laboratories, etc. Some benefit options offer larger networks that includes private practice primary care physicians and national networks to cover out-of-area services. The OAP In-network, OAP Low, OAP High and CIGNA Choice Fund plans offer the largest provider networks.	OAPIN OAP High OAP Low Choice Fund
Q: Do you like having the flexibility of seeing providers who are outside of the plan's network? **A:** The OAP Low, OAP High and Choice Fund plans offer coverage by providers who are not in the plan's network.	OAP High OAP Low Choice Fund
Q: Is having direct access to network providers without a referral important to you? **A:** For the OAP In-Network, OAP Low, OAP High and Choice Fund plans, NO referral to network specialists is required. Additionally, no PCP selection is necessary.	OAPIN OAP High OAP Low Choice Fund

Find out how the plans work and compare plans to determine which plan works best for you.
Log on to **www.mycignaplans.com** using
Enrollment ID: maricopacounty2011 and **password**: cigna

Medical Plans

Administered by CIGNA

This section provides a brief summary of information on the different medical plans offered, how they operate and the cost of services and premiums. For more detailed information, please contact the CIGNA Pre-Enrollment or customer service phone number listed in the "**Who to Contact**" section. Choices include CIGNA Medical Group (CMG), a managed-care HMO plan with a limited CIGNA primary care physician and specialist network, Open Access Plus In-Network (OAPIN), an HMO plan with open access to primary care physicians and specialists within the CIGNA provider network, Open Access Plus (OAP), an HMO plan with open access to primary care physicians and specialists both within the CIGNA provider network and outside of their network, and CIGNA Choice Fund, a high deductible PPO plan, that comes with a Health Savings Account. Some plans have a high and a low option from which to choose. High options have higher premiums but lower copayments and co-insurance for services while low options have lower premiums but higher copayments and co-insurance.

Premium Reductions

Non-tobacco using employees and their covered dependents that have been tobacco free for at least 6 months receive a premium reduction of up to $480 per plan year off ($20 per pay period, 24 times per plan year) of their medical plan premium. In order to receive the non-tobacco user premium reduction, employees must complete and pass a saliva test that detects the use of nicotine. The saliva test applies only to the employee and not to his/her dependents. Refer to the "Wellness Initiatives and Incentives" table under "**Non-Tobacco User**" for details.

As you complete your enrollment, there are two sets of questions to choose from which indicate that you either took or didn't take the saliva test. Each set also includes the following statements that require your response:

- I am a user of Tobacco products;
- A covered dependent is a user of tobacco products, but I am not;
- No one (employee & covered dependents) uses Tobacco products.

If you do not respond to this question, it will default to "I am a user of Tobacco products" and you will not receive the premium reduction.

"Tobacco User" means the occasional or regular use of a tobacco product including but not limited to: cigarettes, cigars, pipes, snuff, chewing tobacco and any other product containing tobacco within the last six consecutive months. Enrollment in a medical plan requires you to respond to options in the Benefit Enrollment System regarding your Biometric Screening and Health Assessment participation. These initiatives apply only to you, the employee, and not to your covered dependents. When you participate in either or both initiatives, you receive a premium reduction of up to $120 per plan year per initiative ($5 per pay period, 24 times per plan year for each initiative). If you do not respond to these questions, they will default to a non-participation status and you will not receive the premium reduction. Refer to the "Wellness Initiatives and Incentives" table under "**Biometric Screening**" and "**Health Assessment**" for details.

Employees who do not provide accurate information and therefore receive premium reductions for which they are not eligible may be subject to disciplinary action up to and including termination. Additionally, providing inaccurate information regarding tobacco user status may result in the life insurance company rescinding your life insurance coverage.

Other Services

All medical plans include the following, except as noted

24-hour worldwide emergency care.

24-hour Health Information Line[sm]: Provides access to health information from Registered Nurses at any time. When you are not sure where to go to seek non-emergency care, you can call and speak with a nurse who can respond to your health care questions, direct you to the nearest participating medical facility or provide suggestions for helpful home care that may comfort you until you can see your doctor. Call 800-244-6224 and listen for the prompt for the 24-hour Health Information Line or call 800-564-8982. You also have access to the Health Information Library where you can listen to taped programs on hundreds of topics. Refer to the "**Wellness Initiatives and Incentives**" section for information on how to access the list of topics.

Alternative Medicine: Twenty self-referred in-network only alternative medicine visits per plan year are covered. Copayments or co-insurance vary depending on the medical plan selected. A $60 credit for herbal/homeopathic or natural supplies dispensed in conjunction with an office visit is also covered for all plans. Providers in CIGNA's designated alternative medicine network must be used when accessing this benefit. Not all services are available at all locations. Refer to the "Alternative Medicine Information" flyer available on the EB Home page under the Medical tab and then under the "Other Forms and Documents" heading.

Covered services are:

- Physician evaluation and management
- Physical medicine
- Acupuncture/acupressure
- Massage therapy
- Homeopathic consultation
- Biofeedback/guided imagery

Behavioral Health/Substance Abuse: Provided by Magellan Health Services (except for CIGNA Choice Fund medical plan where behavioral health/substance abuse benefits are provided by CIGNA Behavioral Health). Refer to the "**Behavioral Health and Substance Abuse**" section for benefit details.

Case Management: Case management involves you (or your dependents) with specific complex health care needs, such as oncology, burns, heart disease complications and high-risk pregnancies, for which a treatment plan is formulated and implemented by CIGNA to improve your health status. If you (or your dependents) choose to disenroll or not participate in Case Management, you will be charged an additional $250 for related services.

CIGNA Care Network (CCN) Specialist Discount: When selecting in-network specialty care through a CCN, the office visit is offered at a $15 lower copayment for all medical plans (except the Choice Fund medical plan). The CCN is a high-performing cost-effective specialty network that meets certain criteria related to quality and efficiency. Refer to the "**Glossary of Terms**" section to see which specialties participate in the CCN network. CCN providers are identified in the CIGNA online provider directory at **www.cigna.com** by a "Tree of Life" symbol.

Guesting Privileges: Provides access to in-network benefits while your dependents are temporarily absent from the service area. Call the CIGNA Customer Service Department to determine whether your dependent qualifies to participate. Certain restrictions apply.

Healthy Rewards Program: Discounts are provided on alternative health services and health and wellness products such as fitness club memberships, chiropractic services, therapeutic massage, acupuncture, cosmetic dentistry, laser vision correction, vitamins and herbal supplements, and hearing aids and tests. Call 800-870-3470 to find out more information or go online to **www.cigna.com/healthyrewards**.

MDLiveCare: Access to non-urgent consultations with a board-certified, state licensed physician for ages 2 and up via web-cam video-conferencing, telephone or secure email, 24 hours a day, 7 days a week, 365 days a year. Enrollees in all medical plans, except Choice Fund, can use the service for a $10 copay per visit. Choice Fund enrollees are charged $39.95 per visit. Services are available online at **www.mdlivecare.com/maricopa** or by calling 888-632-2738.

myCIGNA.com: Access your benefit and claim information, request an ID card, view your provider directory, change your PCP, take your Health Assessment and more through this secure online Web site.

Pharmacy Benefit: Provided by Catalyst Rx (except for CIGNA Choice Fund medical plan where the pharmacy benefit is provided by CIGNA). You will select your pharmacy benefit separately from your medical plan. Refer to the "**Pharmacy Benefit**" section for plan choices and benefit details.

Urgent Care: Urgent care situations require prompt medical attention, but are not emergencies. If you go to urgent care seeking medical treatment and the urgent care provider directly refers you to the emergency room, your urgent care copay or co-insurance will be reimbursed once CIGNA processes the emergency room claim. It may take up to 30 business days to receive reimbursement from CIGNA for your urgent care copay. If you have questions regarding your reimbursement please call CIGNA customer service. Urgent care locations within a CMG Health Care Center can be viewed at **http://www.maricopa.gov/benefits/pdf/2011/CIGNA/cmg_poster.pdf**. For a full list of all of the urgent care locations in your area, visit the online CIGNA provider directory at **www.cigna.com**.

Vision Benefit: Provided by EyeMed Vision Care. See the "**Vision Benefit Plan**" section for benefit details.

Wellness Programs: **Well Aware for Better Health** is an integrated disease management program helping CIGNA members manage cardiovascular disease. To see if you qualify, call 800-249-6512. Once you are enrolled in the disease management program, you can contact a nurse or dietician for consultation at 877-888-3091.

Healthy Pregnancies, Healthy Babies is another wellness program for prenatal guidance, available by calling 800-244-6224. An incentive is available when you complete this program. If you enroll during the first trimester you will receive $150, or $75 for second trimester enrollment.

Additional wellness programs are available to employees enrolled in County medical and/or pharmacy plans. Please refer to the "**Wellness Initiatives and Incentives**" section for further information.

CIGNA Administers the Medical Plan

If you have questions regarding covered benefits, claims payment, the appeal process or a provider's participation status, contact CIGNA Customer Service Department, 24 hours per day, 7 days per week. See the "**Who to Contact**" section for details. Additional resources include CIGNA's Web sites **www.cigna.com**, **www.mycigna.com**, and **www.mycignaplans.com**.

Medical claims are mailed to:

CIGNA
P.O. Box 182223
Chattanooga, TN 37422-7223

Brief summaries of each plan follow. The detailed Plan Descriptions are available on the EB Home page, under the Medical tab.

Preventive Health Coverage

Quick Reference Guide

Your medical plan focuses on helping to keep you well, rather than just providing coverage for covered illness or injury. Your plan includes coverage for wellness services for women, men & children, generally at no cost.

Your doctor will determine the tests that are right for you based on your age, gender & family history. Listed below are some services commonly provided as preventive care.

Wellness Exams & Immunizations

	Birth to 2 Years	Ages 3 to 10	Ages 11 to 21	Ages 22 & older
Well-baby/Well-child/ Well-person exams *(includes height, weight, head circumference, BMI, history, anticipatory guidance, education regarding risk reduction, psychosocial/behavioral assessment)*	Birth, 1, 2, 4, 6, 9, 12, 15, 18, 24 & 30 months. Additional visit at 2-4 days for infants discharged less than 48 hours after delivery	Well child exams; once a year	Once a year	Periodic visits, depending on age
Diphtheria, Tetanus Toxoids & Acellular Pertussis *(DTaP)*	2, 4 & 6 months & 15-18 months	Ages 4 -6	Tetanus, diphtheria, acellular pertussis (Tdap) given once, ages 11-64	Tetanus & diphtheria toxoids booster (Td) every 10 years; Tdap given once, ages 11-64
Haemophilus Influenzae type b conjugate *(Hib)*	2, 4 & 6 months & 12-15 months			
Hepatitis A *(HepA)*	12-23 months			May be required for persons at risk
Hepatitis B *(HepB)*	At birth, 1-4 months & 6-18 months	Ages 3-10 if not previously immunized	Ages 11-18 if not previously immunized	May be required for persons at risk
Human Papillomavirus *(HPV)*[1]		Ages 9-10, as doctor advises	Ages 11-12, catch-up, ages 13-26	Catch-up, through age 26
Influenza Vaccine		Annually 6 months through 18 years	Ages 19-49, as doctor advises	Ages 19-49, as doctor advises; ages 50 & older, annually
Measles, Mumps & Rubella *(MMR)*	Ages 12-15 months	Ages 4-6 or 11 & 12 if not given earlier	If not already immune	Rubella for women of childbearing age if not immune
Meningococcal *(MCV)*			All persons ages 11-18	
Pneumococcal *(Pneumonia)*	2, 4 & 6 months & 12-15 months			Ages 65 & older, once (or younger than 65 for those with risk factors)
Poliovirus *(IPV)*	2 & 4 months & 6-18 months	Ages 4-6		
Rotavirus	Ages 6-24 weeks			
Varicella *(Chickenpox)*	Ages 12-18 months	Ages 4-6	Second dose catch-up or if no evidence of prior immunization or chickenpox	Second dose catch-up or if no evidence of prior immunization or chickenpox
Zoster				Ages 60+

Health Screenings & Interventions

	Birth to 2 Years	Ages 3 to 10	Ages 11 to 21	Ages 22 & older
Alcohol misuse				All adults
Aspirin to prevent cardiovascular disease[2]				Men ages 45-79; women ages 55-79
Autism	18, 24 months			
Blood Pressure		At each visit	Once a year	Every 2 years or as doctor advises
Cholesterol/Lipid Disorders	Screening of children & adolescents (after age 2, but by age 10) at risk due to known family history; when family history is unknown; or with personal risk factors (obesity, high blood pressure, diabetes)		Ages 20 & older if risk factors	All men ages 35 & older, or ages 20-35 if risk factors. All women ages 45 & older, or ages 20-45 if risk factors
Colon Cancer Screening *Please note that a deductible &/or copay/co-insurance may apply if the procedure results in a diagnostic determination (i.e., removal of polyps) found during the procedure. The procedure changes from a screening to a diagnosis at this point.*				The following tests will be covered for colorectal cancer screening, ages 50 & older (or at any age if risk factors): • Fecal occult blood test (FOBT) or fecal • immunochemical test (FIT) annually • Stool-based deoxyribonucleic acid • (DNA) test • Flexible sigmoidoscopy every 5 years • Double-contrast barium enema (DCBE) • every 5 years • Colonoscopy every 10 years • Computed tomographic colonography • (CTC)/virtual colonoscopy every 5 years
Congenital Hypothyroidism Screening	Newborns			
Depression Screening			Ages 12-18	All adults
Developmental Screening	7, 18 months	30 months		
Developmental Surveillance	Newborn 1, 2, 4, 6, 12, 15, 24 months	At each visit	At each visit	
Diabetes Screening				Ages 45 & older, or at any age if asymptomatic with sustained BP greater than 135/80, every 3 years

	Birth to 2 Years	Ages 3 to 10	Ages 11 to 21	Ages 22 & older
Dental Caries Prevention *(Evaluate water source for sufficient fluoride; if deficient prescribe oral fluoride)*[2]	Children older than 6 months	Children older than 6 months		
Oral Health Evaluation/ Assess for Dental Referral	12,18, 24 months	30 months, 3, 6 years		
Hearing Screening *(not complete hearing examination)*	All newborns by 1 month	4, 5, 6, 8 & 10 or as doctor advises		
Healthy Diet/Nutrition Counseling				Adults with hyperlipidemia, those at risk for cardiovascular disease or diet-related chronic disease
Hemoglobin or Hematocrit	12 months		Once a year for females after menarche	
HIV Screening			Adolescents at risk	Adults at risk
Iron Supplementation[2]	6-12 months for children at risk			
Lead Screening	12, 24 months			
Metabolic/ Hemoglobinopathies *(according to state law)*	Newborns			
Obesity Screening		Ages 6 & older	Ages 6 & older	All adults
PKU Screening	Newborns			
Prophylactic Ocular *(Eye)* **Medication to Prevent Blindness**	Newborns			
Prostate Cancer Screening *(PSA)*				Once a year for men ages 50 & older or any age with risk factors
Sexually Transmitted Infections *(STI)* **Screening**			All sexually active adolescents	All adults at risk
Sickle Cell Disease Screening	Newborns			
Syphilis Screening			Individuals at risk	Adults at risk
Tobacco use/cessation interventions				All adults
Tuberculin test	Children at risk	Children at risk	Adolescents at risk	
Ultrasound Aortic Abdominal Aneurysm Screening				Men ages 65-75 who have ever smoked
Vision Screening *(not complete eye examination)*		3, 4, 5, 6, 8 & 10 or as doctor advises	12, 15 & 18 or as doctor advises	

Women's Health Screenings & Interventions

	Birth to 2 Years	Ages 3 to 10	Ages 11 to 21	Ages 22 & older
Anemia Screening			Pregnant women	Pregnant women
Bacteriuria Screening			Pregnant women	Pregnant women
Discussion/Referral for Counseling Related to BRCA1/BRCA2 test			Women at risk	Women at risk
Discussion About Potential Benefits/Risk of Breast Cancer Preventive Medication			Women at risk	Women at risk
Breast Cancer Screening *(Mammogram)*				Women ages 40 & older, annually
Breastfeeding Promotion			During pregnancy & after birth	During pregnancy & after birth
Cervical Cancer Screening *(Pap test)*			Within 3 years of sexual activity	At least every 3 years
Chlamydia Screening			Sexually active women	Sexually active women ages 24 & under & older women at risk
Folic Acid Supplementation[2]			Women planning or capable of pregnancy	Women planning or capable of pregnancy
Gonorrhea Screening			Sexually active women at risk	Sexually active women at risk
Hepatitis B Screening			Pregnant women	Pregnant women
Osteoporosis Screening				Age 65 or older (or 60 for women at risk)
Rh Incompatibility Test			Pregnant women	Pregnant women
Syphilis Screening			Pregnant women	Pregnant women
Tobacco Use/Cessation Interventions			Pregnant women	Pregnant women

[1]Gender criteria apply depending on vaccine brand.

[2]Certain preventive medications noted above may be available to you at no cost. Your doctor will be required to give you a prescription for these medications, including over-the-counter (OTC) medications, for them to be covered under your Pharmacy benefit.

These preventive health services are based on recommendations from the U.S. Preventive Services Task Force (A & B recommendations), the Advisory Committee on Immunization Practices (ACIP) for immunizations, & the American Academy of Pediatrics' Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care. For additional information on immunizations, visit the immunization schedule section of www.cdc.gov. This document is a general guide. Always discuss your particular preventive care needs with your doctor.

Medical Plan Summary Chart

Benefit Provision	CMG High:	CMG Low:	OAPIN:
Type of Plan (as licensed)	HMO		HMO with Open Access to Specialists (similar to a PPO)
Service Area Where Care Must be Received	Maricopa County only, except for emergency care		Nationally
Residency Requirement	Must work or reside in Maricopa County		None
Primary Care Physician (PCP) Required	Yes; may only use PCPs who practice in CIGNA HealthCare Centers		No
Referral Required	Yes, except to obstetrician/gynecologist, urgent care, emergency care, chiropractic care, & alternative medicine		No
Out-of-Network Coverage	No		
Network	AZ-CIGNA Medical Group Network AZ812		National Open Access Plus AZ300
Prior Authorization	Provider's responsibility		

Per Pay Period (24/yr.) Medical Premiums*	Full-time	Part-time	Full-time	Part-time	Full-time	Part-time
Employee	$37.39	$135.47	$34.76	$95.51	$46.65	$149.53
Employee + Spouse	$57.14	$145.66	$48.45	$106.20	$107.10	$163.62
Employee + Child(ren)	$44.92	$142.30	$40.10	$103.66	$84.93	$159.75
Employee + Family	$76.87	$150.68	$61.42	$108.26	$144.37	$169.55

*The premium will be reduced by $20/pay period if the entire household (employee & all covered dependents) is tobacco-free for the past 6 consecutive months & the employee has taken & passed the saliva test; and/or by $5/pay period for voluntarily participating in the biometric screening initiative; and/or by $5/pay period for voluntarily participating in the health assessment initiative.

Find out how the plans work and compare plans to determine which plan works best for you.
Log on to **www.mycignaplans.com** using **User ID:** maricopacounty2011 and **Password:** cigna

Medical Plan Summary Chart

Benefit Provision	OAP High:	OAP Low:	Choice Fund:
Type of Plan (as licensed)	HMO with Open Access to Specialists (similar to a PPO)		High-deductible PPO plan with partially funded Health Savings Account[1]
Service Area Where Care Must be Received	Nationally		
Residency Requirement	None		
Primary Care Physician (PCP) Required	No		
Referral Required	No		
Out-of-Network Coverage	Yes		
Network	National Open Access Plus AZ300		National Preferred Provider Network AZ011
Prior Authorization	Provider's responsibility when in-network. Your responsibility when out-of-network. 50% penalty for no prior authorization.		

Per Pay Period (24/yr.) Medical Premiums*	Full-time	Part-time	Full-time	Part-time	Full-time	Part-time
Employee	$47.55	$154.53	$34.82	$97.98	$30.00	$136.80
Employee + Spouse	$107.64	$169.91	$48.58	$105.45	$30.00	$155.01
Employee + Child(ren)	$86.51	$167.92	$40.29	$104.68	$30.00	$150.72
Employee + Family	$146.94	$179.26	$62.34	$109.08	$30.00	$167.37

*The premium will be reduced by $20/pay period if the entire household (employee & all covered dependents) is tobacco-free for the past 6 consecutive months & the employee has taken & passed the saliva test; and/or by $5/pay period for voluntarily participating in the biometric screening initiative; and/or by $5/pay period for voluntarily participating in the health assessment initiative.

[1]Refer to "Choice Fund Medical Plan with Health Savings Account" section for details.

Find out how the plans work and compare plans to determine which plan works best for you.
Log on to **www.mycignaplans.com** using **User ID:** maricopacounty2011 and **Password:** cigna

Medical Copay/Co-insurance Comparison Chart

Benefit Provision		CMG High
		In-Network Coverage Only
Plan Deductible (These work differently for CMG, OAP and Choice Fund Plans. See "Plan Deductibles" section for details.)	Single	$250 Facility Deductible
	Family	$500 Facility Deductible
Standard Percent of Co-insurance		N/A
Out-of-Pocket Maximum (These work differently for CMG, OAP and Choice Fund Plans. See the "Out-of-Pocket Maximums" section for details)	Single	$1,000
	Family	$2,000
Pre-existing Condition Limitation		None
Preventive Care		$0 (FREE)
MDLiveCare On-Demand Non-Urgent Medical Care		$10
Primary Care Physician Services[1]		$25
Convenience Care Clinic Visit		$15
Specialty Care Physician Services - CCN/Non-CCN		$35* / $50**
Advanced Radiological Imaging: CAT, PET, MRI, MRA Scans and nuclear cardiac studies		$50/type of scan/day***
Allergy Injections - PCP/CCN;Non-CCN		$13* / $28**
Independent Lab and X-ray facility		$0
Inpatient Hospital Facility Services (including delivery)		$50/day, 5 day max, after deductible
Inpatient and Outpatient Professional Services (Surgeon, Radiologist, Anesthesiologist, Pathologist)		$0
Outpatient Hospital Facility Services		$100 after deductible
Pre- & Post-natal Exams (after pregnancy has been determined)		$35* / $50**, waived after 1st visit
Urgent Care (Copay reimbursed if referred directly to Emergency Room)		$75, waived if admitted to hospital
Emergency Room		$175, waived if admitted
Ambulance		$0
Durable Medical Equipment/Medical Supplies No annual limit (copay applies to each item)		$75 DME; $0 consumable supplies
External Prosthetics		$0
Chiropractic Services, Pulmonary Rehab, Physical, Speech, Occupational and Cognitive Therapy; 120 visits maximum combined/yr. except as noted		$25**/provider per day****
Cardiac Rehab; 36 visits/yr.		$25** per visit
Alternative Medicine; 20 visits/yr. maximum; $60 credit for supplies/products		Same as PCP copay
Behavioral Health/Pharmacy		Magellan/Catalyst Rx

For more detail, review the plan summaries on the Benefits Home Page under the Medical tab or compare plans on **www.mycignaplans.com**
User ID: maricopacounty2011 and **Password:** cigna

*You pay lower copays when you use a specialist with the CIGNA Care Network (CCN) designation; for more information see the Glossary of Terms.

**You pay higher copays when you use a specialist without the CCN designation. Not all specialties are included in the CCN. When the specialty is not included in the CCN, the higher Non-CCN copay applies except for therapy & rehabilitation.

***Does not apply to inpatient facility services; subject to applicable place of service co-insurance & plan deductible; Associated ancillary charges are subject to the the applicable place of service co-insurance & deductible.

****Chiropractic visits have a separate 60 visit limit/plan year. Other therapies have a combined 60 visit limit/plan year.

[1]A limited number of primary care physicians are contracted with CIGNA as specialists; in this case the applicable CCN or Non-CCN specialist copay applies.

Medical Copay/Co-insurance Comparison Chart

CMG Low	OAPIN
In-Network Coverage Only	
$300 Facility Deductible	$250 Annual Deductible
$600 Facility Deductible	$500 Annual Deductible
10%	N/A
$5,000	$1,500
$10,000	$3,000
None	Yes, same as for OAP High, Low & Choice Fund Options
$0 (FREE)	$0 (FREE)
$10	$10
$35	$30
$25	$20
$55* / $70**	$40* / $55**
$100/type of scan/day***	$100/type of scan/day***
$18* / $33**	$15* / $30**
$0	$0 after deductible
$150/day, 5 day max, plus 10% after deductible	$200/admit, after deductible
$0	$0 after deductible
$250 plus 10% after deductible	$100 after deductible
$55* / $70**, waived after 1st visit	$40* / $55**, waived after 1st visit
$75, waived if admitted to hospital	$75, waived if admitted to hospital
$175, waived if admitted	$175, waived if admitted
$0	$0 after deductible
$75 DME; $0 consumable supplies	$75 DME after deductible; $0 consumable supplies after deductible
$0	$0 after deductible
$35**/provider per day****	$30**/provider per day
$35** per visit	$30** per visit
Same as PCP copay	Same as PCP copay
Magellan/Catalyst Rx	

For more detail, review the plan summaries on the Benefits Home Page under the Medical tab or compare plans on **www.mycignaplans.com**
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Medical Copay/Co-insurance Comparison Chart

Benefit Provision		OAP High	
		In-Network	*Out-of-Network (of R&C)*
Plan Deductible (These work differently for CMG, OAP and Choice Fund Plans. See "Plan Deductibles" section for details.)	Single	$350 Annual Deductible	$700 (one way accumulation)
	Family	$700 Annual Deductible	$1,400 (one way accumulation)
Standard Percent of Co-insurance		N/A	30% of max reimbursable charge
Out-of-Pocket Maximum (These work differently for CMG, OAP and Choice Fund Plans. See "Out-of-Pocket Maximums" section for details)	Single	$2,000	$4,000
	Family	$4,000	$8,000
Pre-existing Condition Limitation		Yes, same as for OAP Low & Choice Fund Options	
Preventive Care		$0 (FREE)	Covered in-network only
MDLiveCare On-Demand Non-Urgent Medical Care		$10	Covered in-network only
Primary Care Physician Services[1]		$35	30% after deductible
Convenience Care Clinic Visit		$25	30% after deductible
Specialty Care Physician Services - CCN/Non-CCN		$45* / $60**	30% after deductible
Advanced Radiological Imaging: CAT, PET, MRI, MRA Scans and nuclear cardiac studies		$100/type of scan/day***	30%***
Allergy Injections - PCP/CCN;Non-CCN		$18* / $33**	30% after deductible
Independent Lab and X-ray facility		$0 after deductible	30% after deductible
Inpatient Hospital Facility Services (including delivery)		$250/admit, after deductible	30% after deductible
Inpatient and Outpatient Professional Services (Surgeon, Radiologist, Anesthesiologist, Pathologist)		$0 after deductible	30% after deductible
Outpatient Hospital Facility Services		$150 after deductible	30% after deductible
Pre- & Post-natal Exams (after pregnancy has been determined)		$45* / $60**, waived after 1st visit	30% after deductible
Urgent Care (Copay reimbursed if referred directly to Emergency Room)		$75, waived if admitted to hospital	$75, waived if admitted to hospital
Emergency Room		$175, waived if admitted	$175, waived if admitted
Ambulance		$0 after deductible	$0 after deductible
Durable Medical Equipment/Medical Supplies No annual limit (copay applies to each item)		$75 DME after deductible; $0 consumable supplies after deductible	30% after deductible
External Prosthetics		$0 after deductible	30% after deductible
Chiropractic Services, Pulmonary Rehab, Physical, Speech, Occupational and Cognitive Therapy; 120 visits maximum combined/yr. except as noted		$35**/provider per day	30% after deductible/provider per day
Cardiac Rehab; 36 visits/yr.		$35** per visit	30% after deductible
Alternative Medicine; 20 visits/yr. maximum; $60 credit for supplies/products		Same as PCP copay	Covered in-network only
Behavioral Health/Pharmacy		Magellan/Catalyst Rx	

For more detail, review the plan summaries on the Benefits Home Page under the Medical tab or compare plans on **www.mycignaplans.com**
User ID: maricopacounty2011 and **Password:** cigna

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***Does not apply to inpatient facility services; subject to applicable place of service co-insurance & plan deductible; Associated ancillary charges are subject to the the applicable place of service co-insurance & deductible.

****Chiropractic visits have a separate 60 visit limit/plan year. Other therapies have a combined 60 visit limit/plan year.

[1]A limited number of primary care physicians are contracted with CIGNA as specialists; in this case the applicable CCN or Non-CCN specialist copay applies.

Medical Copay/Co-insurance Comparison Chart

OAP Low		Choice Fund	
In-Network	*Out-of-Network (of R&C)*	*In-Network*	*Out-of-Network (of R&C)*
$500 Annual Deductible	$1,000 (one way accumulation)	$1,200 (cross accumulated) Annual Deductible; $500 contribution by Maricopa County to your HSA	
$1,000 Annual Deductible	$2,000 (one way accumulation)	$2,400 (cross accumulated) Annual Deductible; $1,000 contribution by Maricopa County to your HSA	
10%	30% of max reimbursable charge	10%	30% of max reimbursable charge
$5,000	$10,000	$2,000 (cross accumulated)	$2,000 (cross accumulated)
$10,000	$20,000	$4,000 (cross accumulated)	$4,000 (cross accumulated)
If 19 or older, 12 months if treatment was received in prior 90 days. Waived (on month by month basis) with Certificate of Creditable Coverage and for employees & dependents currently covered by a County medical plan for at least 12 months. Certificate of Creditable Coverage must be sent to CIGNA.			
$0 (FREE)	Covered in-network only	$0 (FREE) no deductible	Covered in-network only
$10	Covered in-network only	$39.95	Covered in-network only
$45	30% after deductible	10% after deductible	30% after deductible
$35	30% after deductible	10% after deductible	10% after deductible
$60* / $75**	30% after deductible	10% after deductible	30% after deductible
10%***	30%***	10% after deductible	30% after deductible
$23* / $38**	30% after deductible	10% after deductible	30% after deductible
10% after deductible	30% after deductible	10% after deductible; $0, no deductible if preventive	30% after deductible
$1,000/admit, plus 10% after deductible	$2,000/admit plus 30% after deductible	10% after deductible	30% after deductible
10% after deductible	30% after deductible	10% after deductible	30% after deductible
$500 + 10% after deductible	$1,000 + 30% after deductible	10% after deductible	30% after deductible
$60* / $75** + 10%	30% after deductible	10% after deductible	30% after deductible
$75, waived if admitted to hospital	$75, waived if admitted to hospital	10% after deductible	10% after deductible
$175, waived if admitted	$175, waived if admitted	10% after deductible	10% after deductible
10% after deductible	10% after deductible	10% after deductible	10% after deductible
$75 + 10% DME after deductible; $0 consumable supplies after deductible	30% after deductible	10% after deductible	30% after deductible
10% after deductible	30% after deductible	10% after deductible	30% after deductible
$45**/provider per day	30% after deductible/provider per day	10% after deductible/provider per day	30% after deductible/provider per day
$45** per visit	30% after deductible	10% after deductible	30% after deductible
Same as PCP copay	Covered in-network only	10% after deductible	Covered in-network only
Magellan/Catalyst Rx		CIGNA Behavioral Health/CIGNA Pharmacy	

For more detail, review the plan summaries on the Benefits Home Page under the Medical tab or compare plans on **www.mycignaplans.com**
User ID: maricopacounty2011 and **Password:** cigna

*You pay lower copays when you use a specialist with the CIGNA Care Network (CCN) designation; for more information see the Glossary of Terms.

**You pay higher copays when you use a specialist without the CCN designation. Not all specialties are included in the CCN. When the specialty is not included in the CCN, the higher Non-CCN copay applies except for therapy & rehabilitation.

***Does not apply to inpatient facility services; subject to applicable place of service co-insurance & plan deductible; Associated ancillary charges are subject to the the applicable place of service co-insurance & deductible.

****Chiropractic visits have a separate 60 visit limit/plan year. Other therapies have a combined 60 visit limit/plan year.

[1]A limited number of primary care physicians are contracted with CIGNA as specialists; in this case the applicable CCN or Non-CCN specialist copay applies.

Choice Fund Medical Plan with Health Savings Account

If you are enrolling in the Choice Fund medical plan (also referred to as a high-deductible health plan), generally you are eligible to open and contribute to a Health Savings Account (HSA). There are several rules regarding HSAs, some of which are discussed below.

To open an HSA, you must complete an enrollment package (bank application) which requires your SSN. In order for the bank to verify your enrollment in the Choice Fund medical plan you are required to use your SSN instead of an Alternative ID number.

To qualify for an HSA, you cannot be enrolled in any other type of medical insurance (including Medicare Parts A, B, or D) and can't be claimed as a dependent on someone else's tax return. (If another taxpayer is entitled to claim an exemption for you, you cannot claim a deduction for an HSA contribution. This is true even if the other person does not actually claim your exemption.)

Maricopa County contributes $500 for employee only coverage or $1,000 for employee and dependent coverage to your HSA pro-rated by the number of months remaining in the plan year at time of enrollment. You can contribute up to $3,050 for CY 2011 and $3,100 for CY 2012 (for individual coverage) or $6,150 for CY 2011 and $6,250 for CY 2012 (for family coverage) to your HSA, plus $1,000 catch-up if 55 or older minus the County's contribution. Maricopa County supports payroll deductions into the JPMorgan Chase account based on your annual fiscal plan year contribution amount in the Benefit Enrollment System. Since the benefit plan year is a fiscal plan year which overlaps two calendar years, the annual limits in the Benefit Enrollment System are set at the lower prior calendar year's value. Other contributions to your HSA, such as lump sums, must be handled by you on an after-tax basis outside of the payroll system. Please note there can be certain tax consequences since the plan year is fiscal instead of calendar, if you enroll and contribute a full calendar year's limit by the end of the first calendar year of enrollment and do not continue enrollment in the Choice Fund medical plan for the next 12 months.

Money in your HSA belongs to you, so unused balances are not forfeited at the end of the plan year and are portable if you leave County employment.

You will pay for medical expenses (except for preventive services not subject to the annual deductible) during the plan year until you reach the annual deductible. You can ask the trustee of your HSA to send you a tax-free distribution from your HSA or use your HSA debit card to pay for qualified medical expenses you incur after you establish your HSA. If you receive distributions for other reasons, the amount you withdraw will be subject to income tax and may be subject to a tax penalty. The trustee will report any distribution to you and the IRS on Form 1099-SA. If in the future you become ineligible for an HSA, you can still receive tax-free distributions to pay or be reimbursed for qualified medical expenses from the remaining balance in your HSA.

If you enroll in the Choice Fund medical plan and open an HSA, you can also enroll in the Limited Use FSA for reimbursement of qualified dental and vision expenses. If you are a new enrollee in the Choice Fund medical plan, and you are currently enrolled in a Health Care FSA, and you have not used all of the funds in that FSA prior to opening your HSA, you must incur claims to use up the balance of the FSA funds by June 30th. In this unique situation, you will not have a 2½ month grace period to incur claims because you are not allowed to have both a General Purpose Health Care FSA (not a Limited Use FSA) and an HSA at the same time. Your balance in the Health Care FSA must be zero when the new plan year begins or prior to opening your HSA.

Refer to IRS Publications 969 and 502 for further information regarding the rules for opening, contributing to and withdrawing funds from the HSA. You must file IRS Form 8889 when you file your taxes if you had any activity in your HSA during the tax year. It is also advisable to consult with a tax advisor or IRS Tax Advocate at **www.irs.gov/advocate**, or 877-777-4778 or TTY/TDD 800-829-4059, before enrolling in the Choice Fund medical plan and opening a Health Savings Account.

Plan Deductibles & Out-of-Pocket Maximums

Plan Deductibles

Deductibles work differently depending on the type of plan in which you enroll. Refer to the "Medical Copay/Co-Insurance Comparison Chart" for details.

CMG High and Low Plans

- Deductibles for the CMG High and Low plans apply only to facility-based inpatient and outpatient services.
  - Inpatient facilities include a hospital, skilled nursing facility, rehabilitation hospital, hospice facility, and sub-acute facilities.
  - Outpatient facilities include outpatient hospital surgical center and advanced radiological imaging at an outpatient hospital facility for MRI, MRA, CAT and PET scans.
- Individual and Family deductible amounts aggregate. In other words, all covered members can contribute toward the family deductible amount but one person will not be charged more than the individual deductible amount.
- The deductible must be satisfied before any benefits are payable for facility-based services.

OAP Plans

- Deductibles for the OAP Plans apply to any in-network service except physician or specialist office visits, convenience care office visits, preventive care services, and both in- and out-of-network services at an urgent care facility or the emergency room.
- For the OAP High and Low Plans that have out-of-network coverage, the deductible apples to all out-of-network services except urgent and emergency room services. There are separate deductibles for in-network services and for out-of-network services. These deductibles accumulate one way (from out-of-network to in-network). In other words, if you meet part or all of your out-of-network deductible, that amount will also be used to meet your in-network deductible. However, this does not work in the reverse.
- Individual and Family deductible amounts aggregate. In other words, all covered members can contribute toward the family deductible but one person will not be charged more than the individual deductible amount.
- The deductible must be satisfied before any benefits are payable except as noted above.

Choice Fund Medical Plan

- Deductibles apply to all services except to preventive medical care and preventive medication on the Drug list.
- The deductible is set at the Individual level, if you elect Individual coverage. The deductible is set at the Family level, if you elect Family coverage.
- Family deductible amounts are collective. In other words, all members contribute to the deductible. In this case, one person could meet the entire Family deductible amount.

- The deductibles cross-accumulates. In other words, if you meet all or part of either your out-of-network or in-network deductible, that amount applies to both your out-of-network or in-network deductibles.
- The deductible must be satisfied before any benefits are payable except as noted above.

Out-of-Pocket Maximums

The out-of-pocket maximums work differently, depending on the type of plan in which you enroll. See details below.

CMG High and Low Plans

The out-of-pocket maximum for the CMG High and Low Plans includes:

- member paid medical co-insurance,
- inpatient facility copays,
- outpatient facility copays, and
- advanced radiological imaging copays.

Other copays, such as pharmacy or behavioral health copays, do not count towards the out-of-pocket maximum. Additionally, the medical plan deductible does not count towards the out-of-pocket maximum.

Once the out-of-pocket maximum is reached, inpatient facility copays, outpatient facility copays and advanced radiological imaging copays will no longer be required for the remainder of the plan year.

Individual and Family out-of-pocket maximum amounts aggregate. In other words, all covered members can contribute toward the family out-of-pocket maximum but one person will not be charged more than the individual out-of-pocket maximum amount.

OAP Plans

The out-of-pocket maximum for the OAP Plans includes:

- member paid medical co-insurance,
- inpatient facility copays,
- outpatient facility copays and
- advanced radiological imaging copays.

Other copays, such as pharmacy or behavioral health copays, do not count towards the out-of-pocket maximum. Additionally, the medical plan deductible does not count towards the out-of-pocket maximum.

Once the out-of-pocket maximum is reached, inpatient facility copays, outpatient facility copays and advanced radiological imaging copays will no longer be required for the remainder of the plan year.

Individual and Family out-of-pocket maximum amounts aggregate. In other words, all covered members can contribute toward the family out-of-pocket maximum but one person will not be charged more than the individual out-of-pocket maximum amount.

For plans that have out-of-network coverage, the out-of-pocket maximum accumulates one way, from out-of-network to in-network.

Choice Fund Medical Plan

The out-of-pocket maximum for the Choice Fund Medical Plan includes the medical deductible and all co-insurance including the pharmacy and behavioral health co-insurance.

The out-of-pocket maximum is set at the Individual level, if you elect Individual coverage. The out-of-pocket maximum is set at the Family level, if you elect Family coverage.

The out-of-pocket maximums cross-accumulate between in-network and out-of-network.

Family out-of-pocket maximum amounts are collective. In other words, all members contribute to the out-of-pocket maximum. In this case, one person could meet the entire Family out-of-pocket maximum amount.

Pharmacy Plans

Administered by Catalyst Rx
Rx Bin# 603286/Rx PCN# 01410000

If you (and/or your dependents) enroll in a County-sponsored medical plan, except for the Choice Fund medical plan, you (and/or your dependents) must enroll in one of the pharmacy plans below.

Co-insurance Benefit Plan

The Co-insurance benefit has five levels of coverage in which a co-insurance amount (percentage of the cost[1] of the medication) is charged (unless the applicable minimum or maximum copay applies) based on the classification of the medication per the Preferred Medication List. This list is available on the EB Home page, under the Pharmacy tab. This plan covers generic, preferred brand-name, non-preferred brand-name and specialty medications. Some medications require prior authorization or must be used in a certain order (step therapy). Quantity limits apply for certain medications. Some drug classes, such as infertility, proton pump inhibitors (PPIs) for the diagnosis of gastroesophageal reflux disease (GERD), oral non-sedating antihistamines, erectile dysfunction, non-steroidal anti-inflammatory and cosmetic medications, are excluded. You are responsible for paying 100% of the cost[1] for excluded medications.

You will be charged the minimum or maximum copay or the co-insurance amount for the medication, based on the medication's level and cost. However, if you choose a non-preferred brand-name medication when a generic equivalent is available, you will also pay the difference in the cost between the generic and non-preferred brand-name medication.

The co-insurance or the minimum or maximum copay for covered medication applies to your out-of-pocket maximum, except when a non-preferred brand-name medication with a generic equivalent is purchased, the difference between the brand and the generic equivalent will not count. The out-of-pocket maximum is $1,500 for an individual and $3,000 for a family[2]. One person in a family can meet the individual out-of-pocket maximum. Once the applicable out-of-pocket limit is met, covered medications are paid 100% by the plan for the remainder of the plan year, except for the difference between the non-preferred brand and its generic equivalent, which will continue to be your responsibility.

Annual Out-of-Pocket Maximum
$1,500 Individual / $3,000 Family[2]

	Classification	Up to 30-Day Supply		
Level 1	Generic	$2 Minimum	25% Co-insurance[1]	$12 Maximum[3]
Level 2	Preferred Brand	$5 Minimum	30% Co-insurance[1]	$40 Maximum[3]
Level 3	Non-Preferred Brand with Generic Equivalent	$40 Minimum	50% Co-insurance[1] +	difference between NP brand & generic cost
Level 4	Non-Preferred Brand with No Generic Equivalent	$40 Minimum	50% Co-insurance[1]	
Level 5	Non-Preferred Brand Specialty Drugs	$50 Copay		

[1]Cost of medication is calculated by average wholesale price minus discount percentage or maximum allowable cost. To find the cost of medication, go to **www.walgreenshealth.com**.

[2]Family refers to employee and one or more covered dependents.

[3]Maximums are reduced when mail service is used.

Per Pay Period (24/yr.) Pharmacy Premiums	Full-Time	Part-Time
Employee	$5.57	$14.96
Employee+Spouse	$11.03	$21.26
Employee+Child(ren)	$8.29	$18.35
Employee+Family	$16.56	$27.05

Consumer Choice Benefit Plan

The Consumer Choice Plan has four levels of coverage:

- Level 1 is a County-funded Pharmacy Account. The County will credit an Individual account with $300 or a Family account (family is defined as more than 1 person covered) with $500. In terms of Family coverage, the $500 is available to whichever family members use the pharmacy benefit on a first come, first served basis.
- Level 2 consists of the Employee Deductible and begins when the $300 Individual or $500 Family credit in Level 1 is exhausted. Employees must meet their $300 or $500 deductible before moving to the next level. A family member will move to Level 3 independently, if that individual meets $300 of the $500 family deductible amount.
- Level 3 is Traditional Insurance Coverage where the County pays 80% of the cost and you pay the remaining 20% for the remainder of the plan year.
- Level 4 is limited to Specialty Medications for which a $50 copayment is charged. Specialty medication copayments do not apply to Levels 1 - 3.

For further clarification on the Consumer Choice Pharmacy Plan, refer to the Pharmacy Benefit Plan Description found on the EB Home page, under the Pharmacy tab.

The Consumer Choice benefit is geared towards smart spending through the use of the most cost-effective medication. A preferred medication list (PML) is not used to manage this benefit because much of the management is up to you. Some medications require prior authorization or must be used in a certain order (step therapy). Quantity limits apply for certain medications. Some drug classes, such as infertility, proton pump inhibitors (PPIs) for the diagnosis of gastroesophageal relux disease (GERD), oral non-sedating antihistamines, erectile dysfunction, non-steroidal anti-inflammatory and cosmetic medications, are excluded. You are responsible for paying 100% of the cost[1] for excluded medications.

The amounts you pay toward any covered medication in levels 2 - 4 will apply to your plan year out-of-pocket maximum. The out-of-pocket maximum is $1,500 for individual coverage or $3,000 for family[2] coverage. One person in a family can meet the individual out-of-pocket maximum. Once the applicable out-of-pocket maximum is met, covered prescriptions are paid 100% by the plan for the remainder of the plan year.

Annual Out-of-Pocket Maximum
$1,500 Individual / $3,000 Family[2]

	Certain generic preventive medications are provided at no cost and are not charged or credited against any Levels. The list is available on the EB Home page.			
Level 1	Pharmacy Account	$300 Individual or $500 Family	100% Employer paid[1]	Any unused amount is rolled over to next plan year
Level 2	Employee Deductible	$300 Individual or $500 Family	100% Employee paid[1]	
Level 3	Traditional Insurance Coverage		20%[1] covered by Employee	80%[1] covered by the plan
Level 4	Specialty Medication	$50 copay; does not apply to Levels 1 - 3; rollover amount is not available for specialty medications. Copay applies to out-of-pocket maximum.		

[1]Cost of medication is calculated by average wholesale price minus discount percentage or maximum allowable cost. To find the cost of medication, go to www.walgreenshealth.com.

[2]Family refers to employee and one or more covered dependents.

Per Pay Period (24/yr.) Pharmacy Premiums	**Full-Time**	**Part-Time**
Employee	$0.00	$9.17
Employee+Spouse	$0.00	$10.10
Employee+Child(ren)	$0.00	$9.88
Employee+Family	$0.00	$10.50

Co-insurance & Consumer Choice Benefit Plans

Three-month supply at Advantage90™ retail pharmacies – When you need maintenance medications for chronic or long-term health conditions, you must purchase a three-month supply at an Advantage90™ pharmacy or through mail service, after the initial fill and one refill of a 30- day (or less) supply. The physician must write your prescription for an 84-91 day supply. The Maintenance Medication list is located on the EB Home Page, under the Pharmacy tab.

Three-month supply through mail service pharmacy – Prescriptions for maintenance medications for chronic or long-term health conditions can be ordered through the Walgreens Mail plan services. Besides being convenient, you could save money! Maximum copayments and co-insurance percentages for the Co-insurance plan are reduced when mail service is used. Level 1 (generic) has 15% co-insurance (10% savings) with a maximum of $28, and Level 2 (preferred brand) has 25% co-insurance (5% savings) with a maximum of $70. To register for mail service, go to **www.walgreenshealth.com** and click on the link "Enroll online or print mail service registration forms" at the bottom of the Home page. If purchasing medication in a three-month supply is financially problematic, consider enrolling in either the Choice Fund medical plan that uses the CIGNA pharmacy plan and does not require you to purchase maintenance medication in three-month quantities, or enrolling in the Health Care FSA. The Health Care FSA allows you to set aside pre-tax dollars to use for medical-related expenses. A debit card is issued to access those pre-tax dollars and the debit card allows you to pay for your medication in advance of you making your full annual FSA contribution. Additionally, if you enroll in the Co-insurance or Consumer Choice pharmacy plan and have your prescriptions filled at the onsite pharmacy located on the second floor of the County Administration building, located at 301 W Jefferson St., incentives are available. Refer to the "Wellness Initiatives and Incentives" section, "Onsite Pharmacy".

Note: A 30-day supply of diabetic medication and supplies may be purchased at a Cigna Medical Group pharmacy on an ongoing basis. If you are enrolled in any medical plan, except Choice Fund, you will be charged a $10 copay for each prescription. (Choice Fund members will be charged according to the Choice Fund plan design. For example, if you have not met your annual deductible, you'll be charged the full contracted cost of the supplies. If you've met your deductible, you'll be charged 10% of the contracted cost.) Show your CIGNA medical ID card to purchase your medication and/or supplies in a 30-day quantity for $10 per prescription so that the service will be charged to your medical plan instead of to your pharmacy plan.

Note: You and/or your covered dependents (of any age) may voluntarily enroll in the Maricopa County Diabetic Management Program to qualify for free diabetic medications and supplies, if you have elected either the Co-insurance or Consumer Choice pharmacy plan. Once you or your dependent meets the program requirements, you will receive all covered diabetic medications and supplies free of charge for one year. Annual recertification is required to continue participation. You and/or your covered dependents age 18 and above may also enroll (independent from the Diabetic Management Program) in the Walgreens Optimal Wellness Diabetes Care Management

Program. Upon completion of this year-long educational program, you will be reimbursed for up to 9 diabetic-related office visit copays for the plan year. For information regarding these programs or to request enrollment, please call Employee Benefits at 602-506-1010 or email **BenefitsService@mail.maricopa.gov**.

Pharmacy Plan for Choice Fund Medical Plan

Administered by CIGNA
Rx Bin# 600428/Rx PCN# 02150000

If you enrolled in the Choice Fund medical plan, your pharmacy benefit is automatically provided through CIGNA. The CIGNA pharmacy plan consists of three levels of coverage where co-insurance is charged after the plan deductible is met, except for preventive medications.

The CIGNA pharmacy plan uses CIGNA's drug list, available on **www.cigna.com**, and covers medication on a co-insurance basis, usually after the annual deductible is met. Certain medications are excluded and some medications require prior authorization.

The deductible does not apply to any preventive medications. Additionally, generic and preferred-brand preventive medications are provided at no cost. To determine if the medication is classified as preventive, and/or to determine the drug level (generic, preferred brand or non-preferred brand), access the Drug list located on **www.cigna.com** under "Customer Care". Search results show if the medication is preventive (the initials PM will be listed after the name of the medication) and the drug level to which the medication is assigned.

This plan provides coverage for medication up to a 30-day supply each month when purchased from a participating pharmacy in the CIGNA pharmacy network. A 90-day supply may be purchased through CIGNA Tel-Drug.

The cost of medication may vary by pharmacy. Refer to **www.cigna.com** for a cost comparison tool located under the "My Plans" tab and then the "Pharmacy" tab. Click on the link "Get a prescription drug price quote" under the "Price a Medication" heading. By clicking this link, you will be able to obtain the cost of your prescription drugs, check for generic drug equivalents, and find out if a specific drug is covered.

Note: Diabetic medication not on the Preventive Medication List and diabetic supplies have a 30%, 40% or 50% co-insurance, after the annual deductible has been met. If the diabetic medication is on the Preventive Medication List and is classified as either generic or preferred-brand name, you will not be charged. If the diabetic medication is on the Preventive Medication List as non-preferred brand name, you will be charged 50% (with no deductible). Insulin pumps and supplies can be purchased through CareCentrix for 10% after the annual deductible has been met. Contact Carecentrix at 800-808-1902.

CIGNA Pharmacy Plan for Choice Fund Medical Plan

Level 1	Generic	30% after deductible
Level 2	Preferred Brand	40% after deductible
Level 3	Non-Preferred Brand	50% after deductible
Generic and preferred-brand preventive medications are provided at no cost. (Annual deductible does not apply to generic, preferred-brand and non-preferred-brand preventive medications).		

There is not a separate premium charge for this plan because it is included in the Choice Fund medical plan premium.

Vision Plan

Administered by EyeMed Vision Care

You will automatically be enrolled in the vision benefit. If you are enrolled in a County medical plan, enrollment in the vision benefit cannot be waived. If you waived the County medical plan, you can enroll in the stand-alone vision plan.

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Exam with Dilation as Necessary	$10 Copay	$30
Exam Options:		
Standard Contact Lens Fit and Follow-Up*	Up to $40	N/A
Premium Contact Lens Fit and Follow-Up**	10% off retail price	N/A
Frames:		
Any available frame at provider location	$130 allowance, 20% off balance over $130	$50
Standard Plastic Lenses:		
Single Vision	$10 Copay	$25
Bifocal	$10 Copay	$40
Trifocal	$10 Copay	$55
Lenticular	$10 Copay	$55
Lens Options:		
UV Coating	$15	N/A
Tint (Solid and Gradient)	$15	N/A
Standard Scratch-Resistance	$15	N/A
Standard Polycarbonate	$0	Up to $25
Standard Polycarbonate for Children under 19	$0	Up to $25
Standard Anti-Reflective Coating	$45	N/A
Standard Progressive (Add-on to Bifocal)	$75	Up to $40
Premium Progressive	$75, 80% of charge less $120 allowance	Up to $40
Other Add-ons and Services	20% off retail price	N/A
Contact Lenses: *(Contact lens allowance covers materials only)*		
Conventional	$0 Copay, $130 allowance, 15% off balance over $130	$130
Disposables	$0 Copay, $130 allowance; plus balance over $130	$130
Medically Necessary	$0 Copay, Paid-in-Full	$250
LASIK and PRK Vision Correction	$150 allowance; once per lifetime per eye	N/A
Frequency:		
Examination	Once every 12 months	
Frame	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	

*Standard Contact Lens Fitting - spherical clear contact lenses in conventional wear and planned replacement (Examples include but not limited to disposable, frequent replacement, etc.)

**Premium Contact Lens Fitting - all lens designs, materials and specialty fittings other than Standard Contact Lenses (Examples include toric, multifocal, etc.)

Acute Care Benefit: To enable continuity of eye health care services, an Acute Primary eye care program is available to you at no cost when you use a contracted provider. You are covered for urgent eye care conditions, such as ”pink eye”, as well as progressive conditions that result in vision loss. Treatment for chronic conditions such as glaucoma or diabetes (except refraction) must be received through your medical benefit and medical provider.

Additional Discounts

Additional Eyewear - Save up to 40% off additional complete pairs of glasses after the initial benefit has been used at any participating provider.

Eye Care Supplies - Receive 20% off retail price for eye care supplies like cleaning cloths and solutions purchased at participating providers (not valid on doctor's services or contact lenses).

Laser Vision Correction - Save 15% off the retail price or 5% off the promotional price for LASIK or PRK procedures from US Laser Network.

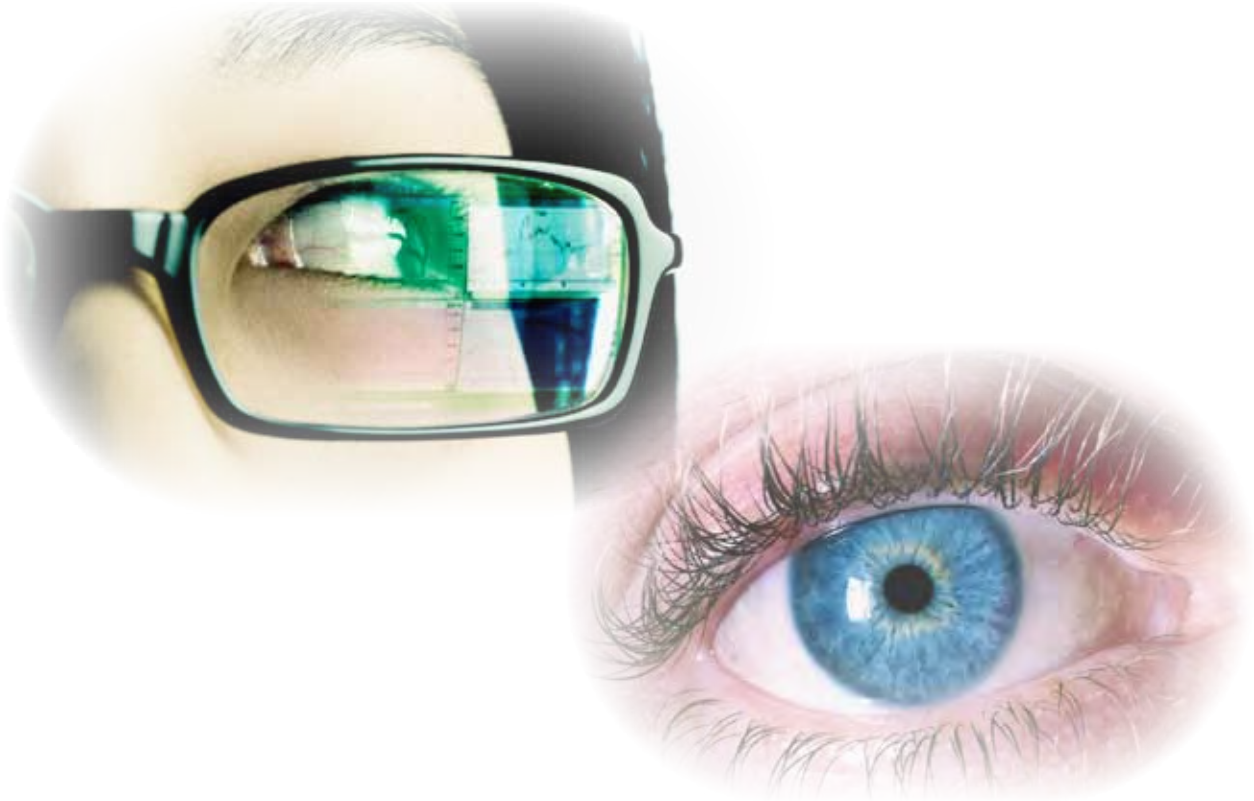
Replacement Contact Lens Purchases - Visit **www.eyemedcontacts.com** to order replacement contact lenses for shipment to your home at less than retail price.

Per Pay Period (24/yr.) Vision Premiums w/Medical Plan	Full-time	Part-time
Employee	$0.42	$0.42
Employee + Spouse	$0.78	$0.78
Employee + Child	$0.82	$0.82
Employee + Family	$1.20	$1.20

Per Pay Period (24/yr.) Vision Premiums w/o Medical Plan	Full & Part-time
Employee	$5.35
Employee + Spouse	$10.10
Employee + Child	$10.58
Employee + Family	$15.53

For more detail, review the vision plan documents on the EB Home page, or contact EyeMed (refer to "**Who to Contact**" section).

The information and benefits described herein are brief summaries of the County's official plan documents and contracts that govern the plans. If there is a discrepancy between the information in this booklet and the official documents, the official documents will govern.



Behavioral Health Plan & Employee Assistance Program

Maricopa County offers both an Employee Assistance Program (EAP) for all employees and their household members, and Behavioral Health and Substance Abuse plans for employees and their dependents that are enrolled in a County-sponsored medical plan.

Sometimes employees face problems that they cannot solve. Concerns can become overwhelming and affect work performance, personal happiness, family relations and health. When this occurs, professional help may be needed to resolve the problem before it becomes a larger issue. You will be assisted by a behavioral health professional that will ensure your treatment is provided at the most appropriate level of care (through the EAP or the Behavioral Health benefit).

For details about the EAP and Behavioral Health benefits, refer to the Magellan EAP brochure, Magellan Behavioral Health Plan Description or the CIGNA Choice Fund Plan Description located on the EBC/ Intranet at **ebc.maricopa.gov/ehi** or on the Internet Web site at **www.maricopa.gov/benefits**.

EAP

The EAP, offered by Magellan, is an employer-paid benefit for all active employees (not for COBRA participants or retirees) that provides short-term counseling for both personal and work-related issues for you and your dependents. There is no premium charged to you for this benefit and there is no copayment when you use this service.

All employees (including contract and temporary) and the members of their household of any age, including domestic partners, elderly parents, stepchildren, and others such as children in college who may be out of state, may use the EAP services.

The EAP provides a full range of counseling and referral services for individual, family and marital concerns, stress and job-related matters, child and domestic abuse, and legal and financial issues. Counseling is available by phone or in person, depending on your preference.

Counseling

The EAP benefit provides up to eight free individual counseling sessions for you and your dependents per person, per problem, per plan year. If sufficient need is shown, upon your approval, your counselor may encourage other members of your family to participate. Magellan provides the strictest confidentiality possible, as set forth in state and federal statutes. Release of information by the EAP concerning an individual can be given only with your written consent, except where required by law (e.g., when child abuse is suspected or when posing a danger to self or others).

Legal Consultation

Your EAP provides legal consultation services. You can call and be referred to an attorney for a prepaid initial in-person consultation or you can call and receive immediate telephonic consultation on issues such as estate planning, family and divorce law, civil and criminal matters, and more.

Financial Counseling

Your EAP also includes services to help you reach your financial goals. When you call, you will be put in touch with a financial expert who can provide information and answer questions on a wide range of topics, including planning for retirement, debt consolidation, and more.

The Financial Counseling benefit includes thirty days of unlimited assistance with the financial coaching

staff, including a complete financial needs analysis and written plan of action around the presenting financial issue as well as outlier financial issues and goals. At the conclusion of the thirty-day financial coaching experience, employees will be offered the opportunity to continue working with the coach on a self-pay month-to-month subscription basis, the cost of which is guaranteed to be offset by savings created by their coach. The cost of the subscription is available through payroll deduction for $18.44 per pay period.

For more information regarding the EAP or to make an appointment, contact Magellan 24 hours a day, seven days a week. Refer to the "**Who to Contact**" section.

Behavioral Health and Substance Abuse

The Behavioral Health benefit is limited to employees and their dependents that have enrolled in a CIGNA medical plan. If you are enrolled in the Choice Fund medical plan, your behavioral health and substance abuse benefits are provided by CIGNA Behavioral Health. If you are enrolled in any of the other five CIGNA medical plans, your behavioral health and substance abuse benefits are provided by Magellan.

The behavioral health benefit provides services that support your well-being. These services help you deal with a wide range of issues, including:

- Anger management
- Depression
- Eating disorders
- Grief and loss
- Severe stress and anxiety
- Substance abuse

Through these services, you receive confidential counseling whenever you and/or your eligible dependents are faced with a personal challenge All records, including personal information, referrals and evaluations, are kept confidential in accordance with federal and state laws.

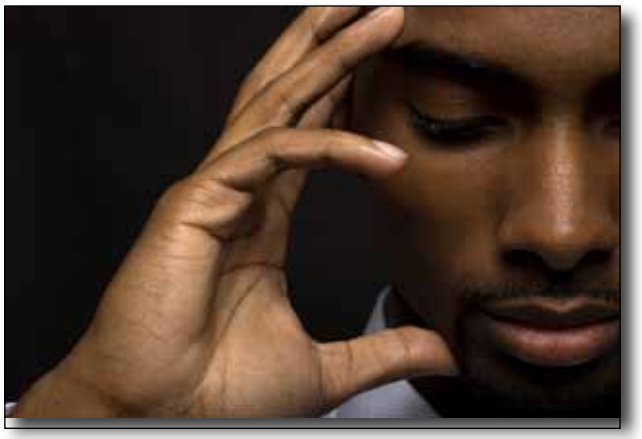
For more information regarding the Behavioral Health and Substance Abuse benefit, contact Magellan or CIGNA Behavioral Health, 24 hours a day, seven days a week. Refer to "**Who to Contact**" section.

Magellan Behavioral Health and Substance Abuse Benefits

If you are enrolled in one of the following CIGNA medical plans, this sub-section applies to you.

CMG High CMG Low OAP In-network OAP High OAP Low

This benefit includes coverage through providers who participate in the Magellan provider network (in-network) as well as limited coverage through providers who do not participate in the Magellan network (out-of-network). From a cost perspective, it is always to your advantage to receive services from in-network providers because you will pay less for the service. This is because Magellan has a contract with the providers in their network to provide a discount off the amount they would normally bill. With out-of-network providers, Magellan pays set dollar amounts depending on the service. You will be billed for the difference. To find a participating provider in Magellan's network, visit Magellan's Web site or call Magellan.



All in-network services require prior approval by Magellan before services are received. Higher levels of care for out-of-network providers (such as inpatient, residential, intensive outpatient, and partial hospitalization) also require prior approval. However, out-of-network outpatient individual or group counseling services do not.

Level of Care	In-Network Benefit	In-Network Rules	Out-of-Network Benefit	Out-of-Network Rules
Inpatient Hospitalization	30 days per year are shared between in and out-of-network benefits $25 copay per day	Preauthorization required	30 days per year are shared between in and out-of-network benefits $500 deductible Plan pays $250 per day after deductible is met. All other costs after plan payment of $250 are member's responsibility	Preauthorization required It is the member's responsibility to obtain preauthorization for initial and concurrent reviews Failure to obtain pre-authorization results in no reimbursement
Partial Hospitalization	Benefit is derived from trading unused inpatient hospitalization days for up to 30 partial hospitalization days per year 30 partial day per year are shared between in and out-of-network benefits Trade at 2 partial days for 1 inpatient day $20 copay per day	Preauthorization required	Benefit derived from trading unused inpatient hospitalization days for up to 30 partial hospitalization days per year 30 partial days per year are shared between in and out-of-network benefits Trade at 2 partial days for 1 inpatient day $250 deductible Plan pays $125 per day after deductible. All costs after plan payment of $125 are member's responsibility	Preauthorization required It is the member's responsibility to obtain preauthorization for initial and concurrent reviews Failure to obtain preauthorization results in no reimbursement
Residential	60 days per year $12.50 copay per day	Preauthorization required	No benefit	N/A
Intensive Outpatient (IOP)	45 IOP visits per year are shared between in and out-of-network benefits $100 copay per program	Preauthorization required $100/program copay applies to a continuous episode of care in IOP. If patient discontinues & restarts program, a new $100 copay is applied	45 IOP visits per year are shared between in and out-of-network benefits Plan pays $40 per visit. All other costs after plan payment of $40 per visit are member's responsibility	Preauthorization required It is the member's responsibility to obtain preauthorization for initial and concurrent reviews Failure to obtain preauthorization results in no reimbursement
Outpatient therapy (individual, family, and medication evaluation)	Unlimited visits per year $20 copay per visit	Preauthorization required	Unlimited visits per year Plan pays $25 per visit. All other costs after plan payment of $25 per visit are member's responsibility	No preauthorization
Outpatient Group Psychotherapy	Unlimited visits per year $5 copay per visit	Preauthorization required	Unlimited visits per year Plan pays $15 per visit. All other costs after plan payment of $15 per visit are member's responsibility	No preauthorization
Ongoing Medication Management	$10 copay per visit Not subject to outpatient visit limits	Preauthorization required	Plan pays $25 per visit. All other costs after plan payment of $25 per visit are member's responsibility Not subject to outpatient visit limits	No preauthorization
Lifetime Maximums	No lifetime maximum		No lifetime maximum	
Annual Limits:	None			

The premium for the behavioral health benefit is included in the medical premium.

CIGNA Behavioral Health and Substance Abuse Benefits

If you are enrolled in the Choice Fund medical plan, this sub-section applies to you.

This benefit includes coverage through providers who participate in the CIGNA provider network (in-network) as well as limited coverage through providers who do not participate in the CIGNA network (out-of-network). From a cost perspective, it is always to your advantage to receive services from in-network providers because you will pay less for the service. This is because CIGNA has a contract with the providers in their network to provide a discount off the amount they would normally bill. With out-of-network providers, CIGNA pays the Maximum Reimbursable charge, after the annual deductible has been met. You will be billed for the difference.

When receiving services from a provider within the CIGNA network, only inpatient hospitalization requires prior authorization. The in-network admitting provider will obtain prior authorization on your behalf. All other services received in-network are on a self-referral basis. To locate a participating provider, use the online CIGNA provider directory.

All out-of-network services require prior authorization. When you go out-of-network, it is your responsibility to obtain prior authorization before receiving services. Contact CIGNA to begin the authorization process.

Mental Health and Substance Abuse	In-network Benefit	Out-of-network Benefit
Inpatient	10% after plan deductible; 60 days combined maximum per plan year	30% after plan deductible; 60 days combined maximum per plan year
Outpatient	10% after plan deductible; unlimited visits per plan year	30% after plan deductible; unlimited visits per plan year
Outpatient Group Therapy Mental Health (MH) *(One group therapy session equals one individual therapy session)*	10% after plan deductible	30% after plan deductible; unlimited visits per plan year
Intensive Outpatient Mental Health *Maximum: Up to 3 programs per plan year based on ratio of 1:1 with outpatient MH visits*	50% after plan deductible	50% after plan deductible
Annual Limits:	None	

The premium for the behavioral health benefit is included in the medical premium.

Combined Rate Sheet

Per Pay Period Total Medical Premiums deducted 24 times/plan year
(includes medical, pharmacy, behavioral health, and vision)

Reduce $20 if employee passed the saliva test and has a tobacco-free household (employee and covered dependents)
Reduce $5 if the employee participates in the biometric screening initiative
Reduce $5 if the employee participates in the health assessment initiative

with Co-insurance Rx		CMG High	with Consumer Choice Rx	
Full-time	Part-time		Full-time	Part-time
$43.38	$150.85	Employee	$37.81	$145.06
$68.95	$167.70	Employee + Spouse	$57.92	$156.54
$54.03	$161.47	Employee + Child(ren)	$45.74	$153.00
$94.63	$178.93	Employee + Family	$78.07	$162.38

with Co-insurance Rx		CMG Low	with Consumer Choice Rx	
Full-time	Part-time		Full-time	Part-time
$40.75	$110.89	Employee	$35.18	$105.10
$60.26	$128.24	Employee + Spouse	$49.23	$117.08
$49.21	$122.83	Employee + Child(ren)	$40.92	$114.36
$79.18	$136.51	Employee + Family	$62.62	$119.96

with Co-insurance Rx		OAPIN	with Consumer Choice Rx	
Full-time	Part-time		Full-time	Part-time
$52.64	$164.91	Employee	$47.07	$159.12
$118.91	$185.66	Employee + Spouse	$107.88	$174.50
$94.04	$178.92	Employee + Child(ren)	$85.75	$170.45
$162.13	$197.80	Employee + Family	$145.57	$181.25

with Co-insurance Rx		OAP High	with Consumer Choice Rx	
Full-time	Part-time		Full-time	Part-time
$53.54	$169.91	Employee	$47.97	$164.12
$119.45	$191.95	Employee + Spouse	$108.42	$180.79
$95.62	$187.09	Employee + Child(ren)	$87.33	$178.62
$164.70	$207.51	Employee + Family	$148.14	$190.96

with Co-insurance Rx		OAP Low	with Consumer Choice Rx	
Full-time	Part-time		Full-time	Part-time
$40.81	$113.36	Employee	$35.24	$107.57
$60.39	$127.49	Employee + Spouse	$49.36	$116.33
$49.40	$123.85	Employee + Child(ren)	$41.11	$115.38
$80.10	$137.33	Employee + Family	$63.54	$120.78

with CIGNA Rx		Choice Fund
Full-time	Part-time	
$30.42	$137.22	Employee
$30.78	$155.79	Employee + Spouse
$30.82	$151.54	Employee + Child(ren)
$31.20	$168.57	Employee + Family

Dental Plan Summary Chart

Administered by:	Employers Dental Solutions (EDS)		CIGNA Dental*		Delta Dental**	
Type of Plan	DHMO (Dental Health Maintenance Organization)		PPO		PPO (but does not use PPO network; see network below.)	
Service Area Where Care Must be Received	State of Arizona		National		National	
Residency Requirement	No		No		No	
Primary Care Dentist Required	Yes, all family members must choose the same dentist		No		No	
Referral Required	No		No		No	
Out-of-Network Coverage	No		Yes		Yes	
Network	EDS Provider Network		CIGNA Dental Network		Delta Premier Network and Delta PPO Network	
Prior Authorization	No		No, predetermination recommended for services over $250		No, predetermination recommended for services over $250	
Location of Provider Directory	www.mydentalplan.net		www.cigna.com		www.deltadentalaz.com	
Per Pay Period (24/yr.) Dental Premiums	**Full-time**	**Part-time**	**Full-time**	**Part-time**	**Full-time**	**Part-time**
Employee	$2.25	$2.25	$7.34	$12.21	$12.66	$17.53
Employee + Spouse	$4.27	$4.27	$16.19	$27.86	$27.94	$39.61
Employee + Child(ren)	$5.60	$5.60	$17.51	$28.80	$30.21	$41.50
Employee + Family	$6.43	$6.43	$22.51	$38.04	$38.85	$54.38

*Includes the CIGNA Dental Oral Health Integration Program®.
**Includes enhanced dental benefits for pregnant women and persons with diabetes.

For more information about these dental wellness programs, see the "Wellness Initiatives and Incentives" section.

Dental Copay/Co-insurance Comparison Chart

Benefit Provision		EDS*	CIGNA Dental***		Delta Dental	
		In-Network coverage only	In and Out-of-Network coverage			
Deductible	Individual	$0	$50		$50	
	Family	$0	$100		$100	
Annual Individual Benefit Maximum	Standard	None / Unlimited	$2,000		$2,000	
	Orthodontic	None / Unlimited	$3,000		$3,000	
Pre-existing Condition Limitation		Procedures in progress at time of enrollment are not covered	5 year waiting period for replacement (major services)		5 year waiting period for replacement (major services)	
Class I - Preventive Care Services			**Amount Paid by the Member**			
Preventive Care Routine Cleanings Sealants Space Maintainers		$0 $12/tooth $20 + lab fees	In-Network	Out-of-Network**	In-Network	Out-of-Network**
			Deductible waived			
			$0	20%**	$0	$0**
Diagnostic Exams Evaluations Consultations & X-rays		$0 - $15	Deductible waived			
			$0	20%**	$0	$0**
Emergency Palliative Treatment Treatment for the relief of pain		Up to $200 reimbursement less applicable copay	Deductible waived			
			$0	20%**	$0	$0**
Class II - Basic Restorative Services			**Amount Paid by the Member**			
Restorative Fillings		Amalgam $9 - $21 Resin $22 - $52	Amalgam 20%	Amalgam 40%**	Amalgam 20%	Amalgam 40%**
			Resin 50%	Resin 50%**	Resin 50%	Resin 50%**
Oral Surgery Extractions		$35 - $120	20%	40%**	20%	20%**
Endodontics Root Canal Treatment Pulpotomy		$170 - $265 $30 - $85	20%	40%**	20%	20%**
Periodontics Treatment of gum disease Periodontal Maintenance		Debridement: $80 Root Planing: $90/quadrant	20%	40%**	20%	20%**
Bridge & Denture Repair		$10 + lab fees	20%	40%**	20%	20%**
Class III - Major Restorative Services			**Amount Paid by the Member**			
Prosthodontics Bridges per pontic Partial Dentures Complete Dentures (upper or lower)		$250 + lab fees $375 + lab fees $325 + lab fees	50%**		50%**	
Restorative Cast Crowns & Jackets Onlays & Inlays		$250 + lab fees $135 - $170	50%**		50%**	
Class IV - Orthodontic Services			**Amount Paid by the Member**			
Orthodontic maximum is separate from annual benefit maximum		25% discount adults & children	50% adults & children		50% adults & children age 8 + older	

*Specialist Care & treatment of TMJ are offered at a discount.

**If the dentist charges more than the reasonable & customary allowance, you will be liable for the difference between the allowance and the billed amount, in addition to the applicable deductible and co-insurance.

***Progressive/Regressive Plan: If you enroll in this plan and you or your covered dependents receive a preventive service during the plan year, the level of coverage is increased for that person by 5% for Class II and Class III services for the next plan year up to a 10% maximum. If you don't receive a preventive service during the plan year, the level of coverage is decreased by 5% for these services for the next plan year. However, level of coverage will not go below that listed above.

For more detail, review the dental plan documents on the **Employee Benefits Dental Page**, or contact the vendor (refer to "**Who to Contact**" section).

How to Look up a Provider Online

CIGNA Medical and Dental Plans – Start at www.cigna.com

Look for the Tree of Life symbol. to identify CIGNA Care Network Specialists to receive a $15 discount on your specialist copay. Refer to the "Medical Plans" section, for more information.

1. From the home page, select the Provider Directory link under "Locate" at top left.
2. Select the radio button next to Physician, Dentist, Pharmacy *(Choice Fund medical plan only)*, Hospital, or Behavioral *(Choice Fund medical plan only)* to find a CIGNA participating provider and enter the search information.
3. Select the radio button next to Urgent Care Centers, Convenience Care Clinic, Mammography Facilities, MRI/CT Facilities, Labs, Colonoscopy Facilities or Other Facilities to find a CIGNA participating facility or ancillary provider and enter the search information.
4. Click on the "Next" button.
5. Continue with the applicable instructions below.

CMG High and Low Options use the AZ – CIGNA Medical Group Network AZ812

1. On the next page, under "What type of plan do you have?" section, select the radio button next to "Network, HMO, POS".
2. From the "Select Healthplan Network" drop-down list, select AZ-CIGNA Medical Group.
3. Under "What you're looking for" section, select the radio button next to "Primary Care Physician" or "Specialist" and the type from the corresponding drop-down list.
4. Click on the "Search" button to view the provider search response.

OAP In-Network and OAP High and Low Options use the National Open Access Plus Network AZ300

1. On the next page, under the "What type of plan do you have?" section, select the radio button next to "Open Access Plus, OA Plus, Choice Fund OA Plus".
2. Under "What you're looking for" section, select the radio button next to "Primary Care Physician" or "Specialist" and the type from the corresponding drop-down list.
3. Click on the "Search" button to view the provider search response.

Choice Fund Health Savings Account (HSA) use the National Preferred Provider Network AZ011

1. On the next page, under "What type of plan do you have?" section, select the radio button next to "PPO, Choice Fund PPO".
2. Under "What you're looking for" section, select the radio button next to "Primary Care Physician" or "Specialist" and the type from the corresponding drop-down list.
3. Click on the "Search" button to view the provider search response.

CIGNA Dental

1. On the next page, under "What type of plan you have" section, choose "CIGNA Dental PPO or CIGNA Dental EPO" and select "Core Network" from the drop-down list. Click on the "Search" button to view the dental search response.

Other Dental Plans

EDS

1. Start at www.mydentalplan.net
2. From the home page, click "Find a Dentist". Or you can choose to print a provider directory.
3. You can search by dentist, location, office name, or specialty. On the home page you can also print a provider directory.

Delta Dental

1. Start at www.deltadentalaz.com
2. Click on Dentists and then Dentist Search
3. When a new page appears, under "1. Product Selection", select "Dental Premier" and continue entering the identifying information
4. Or call 602-938-3131 and select 5 and enter the zip code to hear a listing of dentists in your area

VISION PLAN

EyeMed Vision Care

1. Start at www.eyemedvisioncare.com
2. From the Home page, in the left menu section, click on the drop-down box labeled "Select Your Network" and choose the "Select" option.
3. Enter your zip code where indicated and click the "Submit" button
4. A new window will open and ask you to enter text in the box, click the "Submit" button after entering the text.

PHARMACY PLAN

Catalyst Rx

1. Start at www.walgreenshealth.com
2. From the Home page, if not registered, click on the "Register Now" button. If registered, enter your User ID and Password and click on the Sign In button.
3. Select from the tabs at the top of the page find "Benefit and Coverage" information, "Prescription and Orders", "Payments and Accounting" and "Condition-specific Support".

Life Insurance Plan

Fully Insured by The Standard
Policy Number: 645547

Your Basic and Additional Life insurance, Basic and Additional Accidental Death and Dismemberment insurance, and Dependents Life insurance benefits are provided through The Standard Insurance Company ("The Standard"). Evidence of Insurability (EOI) may be required in certain situations. Once you purchase Additional Life or Dependents Life insurance, you can reduce it or cancel it at any time.

Basic Term Life and Basic Accidental Death & Dismemberment Insurance

The County provides you with, and pays for, Basic Term Life insurance and Basic Accidental Death and Dismemberment (AD&D) insurance equal to your base annual salary (excluding overtime, bonus, commissions, or special work assignment pay and including management and professional assignment pay) rounded up to the next highest $1,000 to a maximum of $500,000. Coverage becomes effective on the date an elected official becomes eligible for benefits, and on the first day of the calendar month following the date any other employee becomes eligible for benefits. Life insurance benefits are paid for any cause of death. In addition to the death benefit, Basic AD&D benefits up to the amount of Basic Life coverage may be payable if an accident is the cause of death or if a dismemberment occurs. EOI is not required for Basic Life and Basic AD&D coverage (except if you were eligible under the prior life insurance plan with Unum Life Insurance Company for more than 31 days but were not insured).

Additional Life Insurance

If you want to increase your Basic Life insurance coverage, you can apply for Additional Life insurance.

The amount of your life insurance coverage may not exceed $1 million of Basic Life and Additional Life combined or Basic AD&D and Additional AD&D combined.

If you purchase Additional Life insurance at the time you are a new hire or when first eligible, you may elect coverage in amounts of 1, 2, 3, 4 or 5 times your base annual salary rounded up to the next $1,000 up to the Guarantee Issue Amount (GIA) of $500,000. EOI is required for an amount greater than the GIA. If you elect more than the GIA, you will be enrolled for coverage up to the GIA until your EOI application for the amount in excess of the GIA is approved.

If you didn't enroll in Additional Life insurance as a new hire or when first eligible, you may apply for any level of coverage (1, 2, 3, 4 or 5 times your annual salary) at any time, but EOI is required to be approved by The Standard before coverage becomes effective.

If you have a qualified status change, you can, within 30 calendar days of that change, enroll in or increase Additional Life coverage (1, 2, 3, 4 or 5 times your base annual salary) without EOI, unless the requested amount is greater than the GIA. EOI is required for an amount greater than the GIA. If you elect more than the GIA, you will be enrolled for coverage up to the GIA until your EOI application for the amount in excess of the GIA is approved. If your EOI application for an increase in coverage is not approved, your coverage will be increased to the next level as long as that level does not exceed the GIA. To learn what constitutes a qualified status change, refer to the "**What is a qualified status change?**" sub-section.

During an Open Enrollment period, you can increase your Additional Life coverage by one level without EOI, provided the increased amount does not exceed the GIA. If you increase your coverage by more than one level or if the increase is over the GIA, you must complete an EOI application. If you do not complete the EOI application, or if your EOI application is not approved, your coverage will be increased to the next level, as long as that level does not exceed the GIA.

Evidence of Insurability

When EOI is required, the "Medical History Statement" form must be completed. The "Medical History Statement" form is available at **www.standard.com/mybenefits/maricopa**. Once the form is completed, it must be submitted to The Standard who will review the information and make a determination whether to approve or deny your request for coverage. The Standard may request further information, such as medical records, tests, or examinations, when making a determination. Coverage and the associated premium do not become effective until The Standard approves your request. For new hires, the effective date of coverage is the first day of the pay period following the date your application is approved. Other approved increases are effective the first day of the calendar month following the date your application is approved, or the following July 1 if you apply during an Open Enrollment period.

Life Features

- Repatriation
  - Available when death occurs more than 75 miles from the insured's primary residence
  - Reimburses the lesser of 2% of life benefit (Basic and Additional) or $2,500, for transportation of an insured's remains to a mortuary near the primary residence
- Accelerated Benefit
  - Applies to insured who is terminally ill with 12 or less months to live
  - Limited to 50% of Basic and Additional life
- Assignment
  - Benefits are not assignable

Medex® Travel Assist Benefit - Group# 7088

Medex® is a comprehensive program of information, referral, assistance, transportation and evacuation services when eligible members are traveling more than 100 miles from home or in a foreign country. The Medex brochure, which contains the ID card, is posted on the Employee Benefits Web site and on The Standard's Web site.

- Services
  - Pre-Trip assistance
  - Medical assistance
  - Emergency transportation services
  - Travel assistance
  - Personal security
  - Medical supplies
- Eligibility
  - Any Maricopa County employee covered by The Standard's Group Life insurance plan and his/her eligible dependents (spouse and/or children up to age 26)

Special Rate for Non-Tobacco Users

As part of the County's commitment to good health, a reward is offered for leading a healthier lifestyle. If you are not a tobacco user, your life insurance premiums are lower than those of an employee who uses tobacco.

Additional Life Insurance Age and Multiplier Table - Employee Only

5 Year Age Categories *(Age on last January 1)*	Employee Cost Monthly per $1,000 of Coverage *(Non-Tobacco User Multiplier)*	Employee Cost Monthly per $1,000 of Coverage *(Tobacco User Multiplier)*	*Tobacco-user rates are controlled by your response to tobacco-use questions on the Additional Life Plan page in the Benefit Enrollment System. It is your responsibility to ensure that these questions are answered accurately.* *Misstatement of your tobacco use status may result in the life insurance company rescinding coverage at the time of death.*
Under 25	$0.040	$0.065	
25-29	$0.047	$0.070	
30-34	$0.062	$0.080	
35-39	$0.070	$0.136	
40-44	$0.092	$0.194	
45-49	$0.150	$0.385	
50-54	$0.230	$0.709	
55-59	$0.390	$0.722	
60-64	$0.660	$1.120	
65-69	$0.950	$1.370	
70 and older	$1.760	$2.250	

Additional Life Insurance Premium Calculator Example

If you are enrolling online through the Benefit Enrollment System, the system calculates your premium automatically.

Take your base annual salary - **example: $24,500**					
Round up to the nearest $1,000	$25,000	$25,000	$25,000	$25,000	$25,000
Multiply by coverage level	1x Salary	2x Salary	3x Salary	4x Salary	5x Salary
Salary amount	$25,000	$50,000	$75,000	$100,000	$125,000
÷ divided by $1,000	**25**	**50**	**75**	**100**	**125**

Refer to the Additional Life Insurance table above to find your age category and tobacco-user or non-tobacco user multiplier

Multiply the result (25, 50, 75, 100, or 125) from the last calculation in the table above by the applicable age and tobacco/non-tobacco user multiplier; then divide by 2 to calculate the per pay period premium (24/yr.)

Example: Age 37	**Multiplier for Non-Tobacco User $0.070**	**Multiplier for Tobacco User $0.136**	**Coverage Amount**
1x Salary	$0.070 x 25 = $1.75/2 = $0.88	$0.136 x 25 = $3.40/2 = $1.70	$25,000
2x Salary	$0.070 x 50 = $3.50/2 = $1.75	$0.136 x 50 = $6.80/2 = $3.40	$50,000
3x Salary	$0.070 x 75 = $5.25/2 = $2.63	$0.136 x 75 = $10.20/2 = $5.10	$75,000
4x Salary	$0.070 x 100 = $7.00/2 = $3.50	$0.136 x 100 = $13.60/2 = $6.80	$100,000
5x Salary	$0.070 x 125 = $8.75/2 = $4.38	$0.136 x 125 = $17.00/2 = $8.50	$125,000

Additional AD&D Benefits

You may purchase Additional AD&D insurance from The Standard. With Additional AD&D insurance, you or your beneficiaries may be eligible to receive an additional amount in the event of death or dismemberment as a result of an accident.

Eligible employees may choose Additional AD&D coverage of 1, 2, 3, 4 or 5 times their base annual salary, rounded to the next $1,000. The maximum amount is $500,000.

You may elect Additional AD&D coverage for yourself only as individual coverage, or you may elect family coverage for you, your spouse and/or child(ren). If you elect family coverage, the amount of AD&D coverage for your spouse and child(ren) will be a percentage of your Additional AD&D insurance as follows:

- Spouse only: 60%
- Child(ren) only: 10% for each child, not to exceed $25,000
- Spouse and child(ren): 50% for your spouse; 5% for each child

You are not required to elect Additional Life insurance in order to elect Additional AD&D.

Voluntary Accidental Death & Dismemberment Family Monthly Cost
$0.035 per $1,000
Employee Only Cost
$0.02 per $1,000

Other Additional AD&D benefit features are listed below:

- Seat Belt
  - Lesser of $25,000 or 10% of AD&D benefit payable for loss of life
    - Applies to an insured driver or passenger as evidenced by police report
- Airbag
  - Lesser of $15,000 or 5% of the AD&D benefit payable for loss of life
    - Applies if seat belt benefit is payable for an insured driver or passenger in position to be protected by airbag as evidenced by a police report
- Career Adjustment
  - Lesser of $10,000 or 25% of the AD&D benefit; $5,000 per year maximum
    - Payable to the surviving spouse
    - Pays tuition expense up to three years after death
- Child Care
  - Maximum of 3% of the amount of the AD&D benefit up to a $2,000 per year maximum
    - Payable to surviving spouse for eligible child(ren)
    - Pays child care expenses (for a licensed provider) up to 72 months after death
- Higher Education
  - Lesser of $40,000 or 25% of the AD&D benefit; $10,000 per year maximum
    - Available to surviving child(ren) at or near high school/college age
    - Pays tuition expense up to four years after the member's death
- Line of Duty
  - Lesser of $50,000 or 100% of the amount of the AD&D benefit payable for the loss of insured public safety officer (does not include corrections, probation, parole or judicial officers)

- Occupational Assault
  - Lesser of $25,000 or 100% of the amount of the AD&D benefit payable for the loss if assaulted while actively at work as evidenced by a police report
- Public Transportation
  - Lesser of $200,000 or 100% of the AD&D benefit payable for loss by a fare paying passenger on public transportation

AD&D Exclusions

AD&D benefits are not payable for death or dismemberment caused or contributed by:

- War or acts of war;
- Suicide or other intentionally self-inflicted injury;
- Injuries sustained while committing or attempting to commit a felony;
- Any drug not used in accordance to the directions of a physician;
- Sickness, pregnancy, heart attack or stroke;
- Medical or surgical treatment for any of the above;
- Boarding, leaving, or being in or on any kind of aircraft. However, this exclusion will not apply if the person who suffers the loss is a fare paying passenger on a commercial aircraft.
- Any loss caused by an accident which arises out of or in the course of any employment for wage or profit.

Dependents (Child and Spouse) Life Coverage

You may elect Dependents life insurance for your eligible dependents (legal spouse and children).

Note: You may not cover your spouse as a dependent if he or she is enrolled for basic life coverage as a Maricopa County employee. Additionally, if you and your spouse are both County employees, only one may enroll dependent children for coverage. Premiums paid for coverage of ineligible dependents will not be reimbursed if you fail to comply with these enrollment requirements past 12 months based on the terms of the contract. Coverage will be limited to one policy as determined by The Standard.

Child Life

Child Life coverage may be purchased for the employee's dependent child(ren) from live birth to age 26. Coverage may also be purchased for a continuously disabled child(ren). You must provide proof of disability to The Standard within 30 days after a) the date insurance would otherwise end because of the child's age or b) the effective date of Maricopa County's coverage under The Standard's policy, if your child is disabled on that date. Contact The Standard to obtain the appropriate form to complete for a disabled child.

The amount of Child Life insurance coverage may not exceed the lesser of $20,000 or the total amount of the employee's life insurance (Basic and Additional combined). Coverage is available in increments of $5,000. EOI is required for Child Life coverage amounts greater than the GIA of $10,000.

If you purchase Child Life insurance at the time you are a new hire or when first eligible, you may elect coverage in amounts up to the GIA. EOI is required for an amount greater than the GIA. If you elect more than the GIA, you will be enrolled for coverage up to the GIA until your EOI application for the amount in excess of the GIA is approved. Your request for coverage that requires EOI will be held pending for 60 calendar days to allow you time to complete the EOI form. If EOI is approved, coverage is effective the first day of the calendar month following the month of approval.

If you didn't enroll in Child Life insurance as a new hire or when first eligible, you may apply for any level of coverage at any time, but EOI is required to be approved by The Standard before coverage becomes effective.

Children (live birth to 25 years if full-time student)	
Monthly Cost (for one or more children)	Coverage Amount
$0.50	$5,000
$1.00	$10,000
$1.50	$15,000
$2.00	$20,000

If you have a qualified status change, you can, within 30 calendar days of that change, enroll in or increase Child Life coverage without EOI, unless the requested amount is greater than the GIA. EOI is required for an amount greater than the GIA. If you elect more than the GIA, you will be enrolled for coverage up to the GIA until your EOI application for the amount in excess of the GIA is approved. If you EOI application for an increase in coverage is not approved, your coverage will be increased to the next level as long as that level does not exceed the GIA. If EOI is approved, coverage is effective the date your qualified status change is processed. To learn what constitutes a qualified status change, refer to the "**What is a qualified status change?**" sub-section.

During an Open Enrollment period, new enrollment or any increase in your Child Life coverage requires EOI.

Spouse Life

Spouse Life coverage may be purchased for the employee's legal spouse.

The premium for Spouse Life coverage is based on the age of the spouse as of January 1 of the current year. In order for the premium to calculate accurately you must ensure that your spouse's age is included on the dependent record in the Benefit Enrollment System. **Note:** When enrolling in the Benefit Enrollment system initially, the spouse life premium calculates on the employee's age, however, when the final calculation occurs and the Confirmation Statement is produced, the correct spouse life premium will display.

The amount of Spouse Life insurance coverage may not exceed the lesser of $100,000 or the total amount of the employee's life insurance (Basic and Additional combined). Coverage is available in increments of $10,000. EOI is required for Spouse Life coverage amounts greater than the GIA of $50,000.

Spouse Life - Monthly Cost	
Age on last January 1	**Spouse**
Under 25	$0.066/$1,000
25-29	$0.077/$1,000
30-34	$0.088/$1,000
35-39	$0.110/$1,000
40-44	$0.132/$1,000
45-49	$0.220/$1,000
50-54	$0.374/$1,000
55-59	$0.594/$1,000
60-64	$0.990/$1,000
65-69	$1.410/$1,000
70 and older	$2.290/$1,000

If you purchase Spouse Life insurance at the time you are a new hire or when first eligible, you may elect coverage in amounts up to the GIA. EOI is required for an amount greater than the GIA. If you elect more than the GIA, you will be enrolled for coverage up to the GIA until your EOI application for the amount in excess of the GIA is approved. Your request for coverage that requires EOI will be held pending for 60 calendar days to allow you time to complete the EOI form. If EOI is approved, coverage is effective the first day of the calendar month following the month of approval.

If you didn't enroll in Spouse Life insurance as a new hire or when first eligible, you may apply for any level of coverage at any time, but EOI is required to be approved by The Standard before coverage becomes effective.

If you have a qualified status change, you can, within 30 calendar days of that change, enroll in or increase Spouse Life coverage without EOI, unless the requested amount is greater than the GIA. EOI is required for an amount greater than the GIA. If you elect more than the GIA, you will be enrolled for coverage up to the GIA until your EOI application

for the amount in excess of the GIA is approved. If your EOI application for an increase in coverage is not approved, your coverage will be increased to the next level as long as that level does not exceed the GIA. If EOI is approved, coverage is effective the date your qualified status change is processed. To learn what constitutes a qualified status change, refer to the "**What is a qualified status change?**" sub-section.

During an Open Enrollment period, new enrollment or any increase in your Spouse Life coverage requires EOI.

Claims Process

Claims must be filed no later than one year after the 90 days immediately following the date of loss. When filing a death claim, a certified death certificate is required. Please contact the Maricopa County Employee Benefits Division in the event of a loss of life or an accidental dismemberment. A Benefits Analyst will assist with providing the Beneficiary Statement form to the beneficiary and completing the Proof of Death form.

Summary of Coverage

Coverage	Who is Covered?	Minimum	Maximum	Evidence of Insurability	Who pays premium?	Monthly Premium
Basic Life	Employee Only	1 x salary	$500,000	None	Maricopa County	.10/1,000
Basic AD&D	Employee Only	1 x salary	$500,000 (matches Basic Life amount)	None	Maricopa County	.02/1,000
Additional Life[1]	Employee Only	1 x salary	5 x salary to a combined total of $1M (Basic + Additional) at new hire, newly eligible or status change. May only increase 1 level during Open Enrollment.	>$500,000 or late applicant	Employee	Based on tobacco use status & age as of Jan. 1
Spouse Dependents Life	Legal Spouse of Employee	$10,000	$100,000 but not more than employee's combined Basic + Additional.	>$50,000, late applicant, or enrollment or increase at Open Enrollment.	Employee	Based on spouse's age as of Jan. 1
Child(ren) Dependents Life	Child(ren) as defined in the group policy	$5,000	$20,000 per child, but not more than employee's combined Basic + Additional per child.	>$10,000, late applicant, or enrollment or increase at Open Enrollment.	Employee	.10/1,000 (for one or more children)
Employee Only (Individual) Additional AD&D[1]	Employee Only	1 x salary	5 x salary to a maximum of $500,000	Does not apply to AD&D	Employee	.02/1,000
Family Additional AD&D[2]	Employee, Spouse and Child(ren)	1 x salary	5 x salary to a maximum of $500,000	Does not apply to AD&D	Employee	.035/1,000

[1]Employee does not have to enroll in Additional Life in order to purchase Additional AD&D

[2]Family coverage includes employee and/or legal Spouse and/or Child(ren). Employee may not be insured for Employee Only Additional AD&D coverage and Family Additional AD&D coverage concurrently. Family coverage amounts are a) 60% of employee's Additional AD&D amount when only a Spouse is covered; b) 10% of employee's Additional AD&D amount up to $25,000 maximum when only a Child(ren) is covered; and c) 50% of employee's Additional AD&D amount for a Spouse and 5% for each Child when both Spouse and Child(ren) are covered.

Portability

If your group coverage ends due to employment termination or retirement, you may be eligible for portable group Life, AD&D and Dependents Life coverage. The portable insurance is available for up to your current coverage amount up to $300,000 for Life and AD&D combined, $100,000 for spouse, and $5,000 for child(ren); or you may decrease the amount of your coverage to the minimum amounts listed in the "Coverage Features" section of the policy.

To apply, contact The Standard within 45 calendar days after your group insurance coverage ends.

Conversion

If you are not eligible for portable coverage, you or your dependents may qualify for conversion coverage.

To apply, contact The Standard within 45 calendar days after your group insurance coverage ends.

Waiver of Premium Benefit

Insurance (all insurance except AD&D) will be continued without payment of premiums while you are totally disabled if:

- You become totally disabled while insured under the group policy and are under age 60;
- Your period of totally disabled will last 180 consecutive days; and
- You provide a satisfactory proof of loss.

Totally disabled means that, as a result of sickness, accidental injury, or pregnancy, you are unable to perform with reasonable continuity the material duties of any gainful occupation for which you are reasonably fitted by education, training and experience.

Waiver of premium ends on the earliest of:

- The date you cease to be totally disabled;
- 90 days after the date The Standard mails you a request for additional proof of loss, if it is not given;
- The date you fail to attend an examination or cooperate with an examiner;
- The date you reach age 65.

It is your responsibility to notify the Employee Benefits Division when you no longer meet the eligibility criteria listed above so that the waiver of premium benefit can be stopped.

Contact Employee Benefits to apply for this benefit. If approved, the waiver of premium will be effective the first of the month following your disability date.

Beneficiaries

You should name a primary and secondary (contingent) beneficiary in the Benefit Enrollment System for your Basic and Additional Life insurance benefits when you become insured.

You may allocate benefits by percentage only using a whole percentage. Primary beneficiary designations must equal 100%. Secondary beneficiary designations must also equal 100%.

You may change your beneficiary at any time. The new beneficiary designation will be effective as of the date you submit an electronic designation during Open Enrollment or make a beneficiary change online through the Benefit Enrollment system.

Short-Term Disability Plan

Administered by Sedgwick CMS

The Short-term Disability Plan (STD) replaces a portion of your monthly salary while you are disabled. There is a 3-week (120 work hour) waiting period from the onset of your disability during which time you are required to use your sick leave. If you do not have 120 hours of sick leave, you must use vacation time during the waiting period. The maximum STD payment period is 23 weeks (26 week benefit - 3 week waiting period = 23 week payment period).

What benefit coverage amount can you elect?

You elect the benefit coverage amount when you enroll for STD coverage. You may elect 40%, 50%, or 60% of your monthly base salary. The maximum benefit is $2,000 per week.

Note: If your weekly disability payment will be at the $2,000 per week maximum, you may be enrolling in a coverage level with a higher premium rate multiplier than necessary. Refer to the STD calculator on the EB Home page to determine the coverage level that charges the lowest premium and will yield the $2,000 per week maximum.

You may only increase or decrease your coverage during Open Enrollment. No changes are allowed during the plan year (July 1 through June 30) except when you become ineligible for benefits (for example, you lose your active employee status due to a reduction in force or you are called to active military duty).

This plan contains a pre-existing condition if you have a condition related to your disability for which you received treatment 90 days before your coverage became effective. In this case, benefits will not be payable for that condition until you have been treatment free for 3 months or covered by the plan for 12 months.

Coverage level increases made during Open Enrollment are subject to the pre-existing condition limitation. For example, if you previously elected 50% benefit coverage and during an Open Enrollment period you changed your election to the 60% benefit coverage, the difference between the 50% and the 60% benefit is subject to pre-existing condition payment criteria. If you become disabled due to a pre-existing condition, your payment would be based on the 50% benefit coverage level until covered by the increased coverage for 12 months.

If your claim is related to a mental health diagnosis, Sedgwick CMS will work with Magellan Health Services to ensure that you receive a disability assessment and care by a licensed mental health professional and that you are assigned a care coordinator who will regularly work with you, Sedgwick CMS and your mental health provider on your treatment plan and your return-to-work goals.

The STD benefit includes a return-to-work incentive designed to lessen the financial hardship that your disability caused by allowing you to return to work on a part-time basis within your restrictions and limitations. Your STD benefit continues to be paid, within certain limits, in addition to your part-time earnings. Refer to the STD Plan Description for an example of this calculation.

How is your benefit payment calculated?

To calculate the amount of your weekly benefit, multiply your base weekly earnings by the percentage of the benefit coverage amount you elected and deduct any other income you are receiving that offsets your benefit. The maximum benefit is $2,000 per week.

Benefits payable for less than one weekly period will be paid at the rate of one-seventh of the STD benefit amount for each day of disability.

How is your Premium Calculated?

The Benefit Enrollment System automatically calculates the premium for you, however, the table below shows the details of the calculation.

Coverage	Multiplier
40%	0.2677%
50%	0.3785%
60%	0.5908%

Annual Base Salary: $25,000	40% Option	50% Option	60% Option
Multiplier	0.002677	0.003785	0.005908
Annual Premium	$66.93	$94.63	$147.70
Deductions Per Year	24	24	24
Per Pay Period Premium *(Per Pay Period Salary x Per Pay Period Multiplier)*	$2.79	$3.94	$6.15

Refer to the Short-Term Disability Plan Description on the EB Home page for further details or Sedgwick CMS (refer to the "**Who to Contact**" section) to file a claim for this benefit.

There is a premium calculator on the EB Home page, under the "Disability" tab, that will help you determine the coverage level that charges the lowest premium to yield the maximum benefit.

Because the maximum weekly benefit is $2,000, the maximum salary subject to premium is:

Coverage	Annual Salary
40%	$260,000
50%	$208,000
60%	$173,333

Flexible Spending Accounts

Administered by ADP

Maricopa County offers two flexible spending accounts (FSAs) that allow you to pay for health care (General Purpose and Limited Use) and/or dependent care expenses on a tax-free basis for your dependents that you claim on your Federal tax return. When you elect to participate in an FSA, your gross income is reduced because your FSA contributions are not subject to Medicare, OASDI, federal or state income taxes. Once you enroll in an FSA, you must re-enroll annually during each Open Enrollment to renew your spending account(s).

Tip: If purchasing maintenance medication in a three-month supply (as required under the Catalyst Rx Co-insurance and Consumer Choice pharmacy plans) is financially problematic, consider enrolling in either the Choice Fund medical plan that uses the CIGNA pharmacy plan that does not require you to purchase maintenance medication in three-month quantities, or the Health Care FSA. Additionally, all of the medical plans have deductibles which may cause you to incur a large out-of-pocket expense. It can be beneficial for you to open a Health Care FSA since your entire annual plan year contribution is available at the beginning of the plan year before you have made your full annual contribution. The FSA also allows you to use the funds in your FSA instead of your own cash when you use the FSA debit card.

When you enroll in the FSA, you will be asked to enter the annual amount of your contribution for the current plan year in the online Benefit Enrollment system. The system automatically divides the annual amount by the number of pay periods remaining in the plan year to determine the per pay period deduction. Deductions are taken 26 times during the plan year. Money that is contributed to an FSA will be forfeited per Proposed IRS Regulation § 1.125-5(c) (1), if not used and/or claimed according to the information and dates below. Forfeited funds revert to the Benefits Trust Fund and are used to offset administrative expenses associated with this FSA Plan.

Incurred Expenses

For active employees, eligible health and dependent care expenses must be incurred during the plan year (July 1 through June 30). For Health Care FSA expenses, there is a 2 ½ month grace period (the following July 1 through September 15) in which expenses can be incurred in order to use any remaining contributions from the prior plan year. If you are currently enrolled in a General Purpose Health FSA with a grace period, and you enrolled in the Choice Fund medical plan for the next plan year and subsequently open a Health Savings Account, then you must incur expenses so that the balance in the General Purpose Health FSA is zero at the end of the current plan year or prior to opening your Health Savings Account.

For terminated (voluntary, involuntary or retired) employees, health and dependent care expenses must be incurred by the benefit termination date. There is no grace period for terminated employees.

Claims Filing Deadline

For active employees, claims for reimbursement for the Health Care FSA must be submitted by November 30th following the end of the plan year. For terminated employees, claims must be submitted within 60 days of your benefit termination date.

For active employees, claims for reimbursement for the Dependent Care FSA must be submitted by August 31st following the end of the plan year. For terminated employees, claims must be submitted within 60 days of your benefit termination date.

Debit Card and Paper Claims

Most Health Care FSA claims can be filed using the ADP-provided debit card at the point of service during the plan year. The debit card can also be used to file claims during the grace period for reimbursement of unused funds from the prior plan year, if you have re-enrolled in the FSA for the new plan year.

The debit card is provided as a payment convenience so that in most cases, you can immediately access your full annual Health Care FSA contribution in advance of payroll deductions being taken for your full annual contribution. There are various regulations that control when the debit card transaction can be accepted with no follow-up documentation. Generally, if you are enrolled in a Maricopa County medical plan, pharmacy copays (except Mail Service claims) and physician office copays do not require you to submit documentation. Follow-up claim documentation will be required for some charges (for example for eye glasses) so be sure to keep your receipts and Explanation of Benefit statements. You will be notified by ADP if you need to send in receipts to substantiate your debit card transaction.

Paper claims may also be filed by completing the claim form located on the ADP Flexdirect Web site.

General Purpose Health Care FSA

You can enroll in the Health Care FSA (unless you enrolled in the Choice Fund medical plan) to pay for eligible health care expenses that are not covered by your insurance (or another Health Savings Account) such as office visit or prescription copays. Eligible expenses are defined by the Internal Revenue Service and can be found in IRS Publication 502.

You can set aside up to $5,200 as your plan year maximum contribution. Deductions are taken 26 times per plan year. A minimum plan annual contribution of $26 is required.

Limited Use Health Care FSA

If you enrolled in the CIGNA Choice Fund medical plan, you can still take advantage of an FSA. However, you and your covered dependents can only enroll in the Limited Use plan. This plan allows you to be reimbursed for dental and vision care services (as defined by the IRS) but not medical expenses.

You can set aside up to $5,200 as your plan year maximum contribution. Deductions are taken 26 times per plan year. A minimum plan annual contribution of $26 is required.

Dependent Care FSA

Dependent Care Flexible Spending Accounts allow you to use pre-tax money to pay for dependent care for your dependents under age 13 or for your spouse or dependent who is physically or mentally incapable of self-care so that you and your spouse are able to work. Refer to IRS Publication 503 for more information.

You can set aside up to $5,000 as your plan year contribution. Deductions are taken 26 times per plan year. A minimum plan annual contribution of $26 is required.

Since your benefit plan year is based on a fiscal year, you will be responsible for controlling your IRS mandated calendar year maximum of $5,000 for the Dependent Care FSA.

Deferred Compensation

Administered by Nationwide Retirement Solutions

To enhance your future, Maricopa County offers you a deferred compensation plan. Your pension plan through ASRS or PSPRS was not designed to provide your entire retirement income, which is why participating in a deferred compensation program is an essential step to achieving financial independence upon retirement. A deferred compensation program allows you to contribute money, before it is taxed, to an account. When you withdraw the monies from your deferred compensation account, typically during retirement, you will have to pay the applicable taxes. However, tax is paid only on the amount you withdraw in a given year. Meanwhile, the rest of your investment has the opportunity to continue to grow tax deferred.

Once you enroll, contributions are deducted from your paycheck. You can make changes to the amount of your contribution at any time that your personal situation changes. The minimum contribution is $10 per pay period. The maximum contribution is 100% of includible compensation, up to $16,500 for calendar year 2011 if you are under age 50. If you are 50 or older, the catch-up provision allows you to contribute an additional $5,500 in 2011. If you are within three years of retirement, you may qualify to contribute more if you have past dollars to "catch up". For this pre-retirement window only, the maximum amount deferrable is the lesser of twice the normal deferral limit ($33,000) or 100% of includible compensation.

You have more than 35 investment choices, as well as a Personal Choice Retirement Account through Schwab if you have at least $5,000 on account. As an added bonus, your money is available to you upon separation from County service with no early withdrawal penalty. Funds are also available for withdrawal for a financial hardship as defined by the IRS, or through the loan provision where you can borrow a minimum of $1,000 up to 50% of the value of your account.

To request a consultation with a retirement specialist, contact Nationwide Retirement Solutions or visit their Web site. Refer to the "**Who to Contact**" section.

MetLaw® Group Legal Services

Administered by MetLife through Hyatt Legal Plans

Finding an affordably priced lawyer to represent you when you have trouble with creditors, buy or sell your home, or need to prepare your will can be a challenge. Now there's a simple, affordable solution. MetLaw is a legal services plan that provides legal representation for you, your spouse and dependents at an affordable price.

Now you have a resource at your fingertips for important, everyday legal services. What's more, you'll also have someone to turn to for unexpected legal matters. With MetLaw, you can receive legal advice and fully covered legal service for a wide range of personal legal matters, including:

- Adoption & Legitimization
- Court Appearances
- Document Review and Preparation
- Debt Collection Defense
- Elder Law Matters
- Family Matters
- Personal Property Protection
- Real Estate Matters
- Security Deposit Assistance
- Traffic Ticket Defense (except DUI/DWI)
- Wills
- And more!

Services are provided from a network of experienced attorneys either on the phone or in person. When you use a Plan Attorney, there are no deductibles, copays, waiting periods, claim forms or limits on usage. You also have the flexibility to use a non-Plan Attorney and be reimbursed for covered services according to a set fee schedule.

The premium for this plan is $7.87 per pay period, 24 pay periods per year.

For more information contact Hyatt Legal Plans or visit their Web site. Refer to the "**Who to Contact**" section.

Auto, Home and Renters Insurance

Administered by Liberty Mutual

As a Maricopa County employee, you qualify for a special group discount* on your auto, home and renters insurance through the Libery Mutual Auto and Home Insurance Program. With this program, you can enjoy the ease and convenience of paying your premiums through payroll or checking account deductions, with no down payment or finance charges. You also will enjoy fast, easy, round-the-clock claims service and a variety of discounts for multi-car, multi-policy, safe-driver, passive restraints and anti-theft devices.*

See for yourself how much money you could save with Liberty Mutual compared to your current insurance carrier. For a free, no-obligation quote, contact Liberty Mutual. Refer to the "**Who to Contact**" section.

*Discounts and credits are available where state laws and regulations allow and may vary by state. Certain discounts apply to specific coverage only. To the extent permitted by law, applicants are individually underwritten; not all applicants may qualify. Coverage is provided and underwritten by Liberty Mutual Insurance Company and its affiliates, 175 Berkeley Street, Boston, MA.

Wellness Initiatives and Incentives

Maricopa County values the health and well being of our employees. That's why we continue to improve our employee worksite wellness program by offering the following health and wellness initiatives and incentives that have been developed for our population based on biometric screening and health assessment results, as well as utilization trends.

We encourage you to participate in the initiatives and incentives for which you qualify in order to learn how you can take more control of your health and well being. If you would like additional information regarding the information below, call the Employee Benefits Division or go the Employee Benefits Home page and click on the Wellness tab. Wellness initiatives are communicated by Weekly Wellness Activities and via the EBC Portal. Please check with your department for its policy on attending wellness initiatives and programs during your scheduled work hours.

Initiative	Description	Who is Eligible?	How to Access Services/Incentives	Cost/Incentive
~ Dental ~				
Brush Biopsy	Early detection of oral cancer through a brush biopsy.	Employees and their covered dependents enrolled in CIGNA Dental PPO.	Information available at http://www.maricopa.gov/benefits/pdf/2010/CIGNA_Dental/oralcancerexam.pdf	In-network: 20% co-insurance after deductible is met. Out-of-network: 40% co-insurance after deductible is met.
Dental Cleanings	A third dental cleaning is available to employees and/or dependents as a way of supporting preventive care, improving health and lowering overall costs for members with the following medical conditions: diabetes, women in their third trimester of pregnancy, renal dialysis patients, suppressed immune system patients (due to chemotherapy, HIV positive, organ transplant, or stem cell/bone marrow transplant) or head and neck radiation patients.	Employees and their covered dependents enrolled in Delta Dental.	Information available at http://www.maricopa.gov/benefits/pdf/2010/Delta_Dental/third_cleaning.pdf	Covered at 100% (deducted from the benefit maximum)
Dental Oral Health Integration Program (OHIP)	Research shows that oral health may have an impact on overall health. Periodontal disease has been linked to complications for heart disease, stroke, diabetes, and pre-term births. This program provides employees and/or dependents with 100% reimbursement of their co-insurance for certain related dental procedures. These procedures include periodontal treatment and maintenance (increased to 4 times per year); periodontal evaluations, an additional oral evaluation, an additional cleaning, emergency treatment for pain, fluoride application and sealants. Please refer to OHIP program materials for covered dental services by medical condition.	Employees and their covered dependents who are enrolled in a County-sponsored CIGNA Dental PPO and who have been diagnosed with stroke, cardiovascular disease, diabetes or chronic kidney disease. In addition, pregnant women, those receiving head and neck cancer radiation or those who have had an organ transplant are covered.	Contact CIGNA Information available at http://www.maricopa.gov/benefits/pdf/2011/CIGNA_Dental/oralhealth.pdf	No Cost

Initiative	Description	Who is Eligible?	How to Access Services/Incentives	Cost/Incentive
~ Diabetes ~				
Diabetes Education	Appointment with a diabetes educator for assessment; Basic diabetes education class series; Continuing diabetes education class; and Intensive insulin management class.	Employees and their covered dependents enrolled in a County-sponsored CIGNA Medical plan.	At several CIGNA HealthCare Centers. See flyer Information available at **http://www.maricopa.gov/benefits/wellness/askdiabetes.aspx**. For general information call 623-876-2355.	Fee based classes
Diabetes Management Program	Meet 8 conditions to participate; Click here to review the brochure.	Employees and their covered dependents (diagnosed with diabetes) enrolled in a County-sponsored Catalyst Rx pharmacy plan.	Information available at **http://www.maricopa.gov/benefits/wellness/diabetes.aspx**	No Cost; Receive free diabetic medications and supplies for one year; annual recertification required for continued participation.
Take Charge of Your Diabetes Walgreens Optimal Wellness Program™	Educational program provided by a diabetic-certified pharmacist over a one-year period. The program is available through Catalyst Rx and the Joslin Diabetes Center, the global leader in diabetes research, care and education, dedicated to improving health outcomes for people with diabetes. The role of the pharmacist is to review your medical history and medications to assess your diabetes control regimen and to recommend ways for you to better manage your condition.	Diabetic employees and their covered dependents who are 18 years of age or older and enrolled in a County sponsored Catalyst Rx pharmacy plan; Participants can enroll and re-enroll annually for the program.	Call 877-924-4584 to enroll, Monday-Friday, 9 AM to 10 PM EST and Saturday 8 AM to 5 PM EST. Contact your health care provider and obtain a copy of your most recent lab tests for A1C, total cholesterol, HDL, LDL, and triglycerides to bring to your first appointment.	No Cost; Upon program completion, participants will be eligible to be reimbursed for up to 9 diabetic-related office visit co-pays for one plan year.
~ Disease Management ~				
Healthy Living Workshop (Chronic Disease Self-Management Program)	Educational program developed by Stanford University for employees or (care givers) with chronic conditions such as asthma, arthritis, diabetes, high blood pressure, low back pain or heart disease. Learn how to live a healthier life with your chronic condition. Six-week course for 2 ½ hours per week. The classes will be facilitated by Maricopa County Department of Public Health	Employees and their covered dependents enrolled in a County-sponsored CIGNA medical plan.	Enroll through Pathlore Course Code: PED136B	No Cost; Receive a workbook, Living a Healthy Life with Chronic Conditions
~ Ergonomics ~				
Ergonomics Classes	Various classes taught by Ergonomic Specialists; Custom classes are available for locations with at least 10 participants.	All employees	Enroll via Pathlore on the EBC Internet. Class Search under "Ergonomic Classes"	No Cost
Ergonomics Evaluation	Evaluation at your individual workstation.	All employees	Go to Employee Benefits Web site and download the ergonomic request service form. Have your supervisor sign the form and fax to 602-506-8974. Some departments have ergonomic facilitators who handle all ergo requests.	No Cost
Ergonomics consult for seating, lighting, furniture, and equipment	Onsite evaluation of facility.	All employees	Go to Employee Benefits Web site and download the ergonomic request service form. Have your supervisor sign the form and fax to 602-506-8974. Some departments have ergonomic facilitators who handle all ergo requests.	No Cost

Initiative	Description	Who is Eligible?	How to Access Services/Incentives	Cost/Incentive
~ Medical Services ~				
24-Hour Health Information Line	A telephonic health information library where you can listen to pre-recorded information on over a hundred health topics. Or, speak to a nurse for answers to your questions, suggestions for helpful home care, or assessment of symptoms and direction to the most appropriate care	Employees and their covered dependents enrolled in a County-sponsored CIGNA medical plan	Call 800-244-6224 and listen for the prompt for the 24-hour Health Information Line or call 800-564-8982 for nurse assistance. To access the list of health information topics, go to **www.mycigna.com**, click on the "My Health" tab at the top of the page, find the "Health Management Resources" heading, then click on the "Health Information Line" link for more information about calling for live support or options to listen to a podcast.	No Cost
Adult Immunizations	Flu/Pneumonia (by Walgreens)	Employees and their covered dependents enrolled in a County-sponsored CIGNA medical plan.	All County-sponsored worksite flu/pneumonia shot clinics will be provided by Walgreens. Appointments will be required via Walgreens online appointment scheduler. You must be 18 years of age or older. You will be required to show your CIGNA medical card. Employees and their covered dependents may receive flu/pneumonia shots at Walgreens pharmacies on a first come, first served basis. You will be required to show your CIGNA medical card.	No out of pocket cost to employees and their dependents with a County-sponsored CIGNA medical card.
	Flu (by CIGNA)	Employees and their covered dependents enrolled in a County-sponsored CIGNA medical plan.	Employees and their covered dependents may receive flu shots at CIGNA HealthCare facilities and CareToday locations during specified hours on a "walk-in" basis.	
	Tdap (Tetanus, Diphtheria and Pertussis) (by CIGNA)	Employees and their covered dependents enrolled in a County-sponsored CIGNA medical plan for Tdap; Note: must meet CDC guidelines for age, frequency and risk	Use the onsite Walgreens pharmacy located on the 2nd floor of the County Administration building.	
Convenience Care Clinics **(Take Care and CareToday Only)**	Walgreens Take Care and CIGNA CareToday clinics, staffed by nurse practitioners or physician assistants, are located throughout the valley and provide treatment for acute, non-urgent and non-work-related injuries such as minor cuts, allergies, ear infections, sinusitis, strep throat, conjunctivitis, urinary tract infections; immunizations such as flu (seasonal), Tdap (tetanus, diphtheria & pertussis), pneumonia, shingles, meningitis, mumps, measles and rubella, chicken pox, hepatitis A and B, and gardasil, are also provided.	Employees and their covered dependents enrolled in a County-sponsored CIGNA medical plan	Use the onsite Take Care clinic located on the 2nd floor of the County Administration building or find a Take Care clinic at **www.takecarehealth.com**. CIGNA CareToday locations are available at **www.cigna.com/cmgaz/index.html** Convenience Care clinics are open 7 days a week including evenings and most holidays. Service is offered on a first come, first served basis.	Receive a $10 discount off your normal PCP co-pay. Choice Fund medical plan participants may be seen by the provider, but will not receive the discount. Choice Fund medical plan members will pay customary charges until the deductible is met, and 10% of the customary charge thereafter until the out of pocket maximum has been met.

Initiative	Description	Who is Eligible?	How to Access Services/Incentives	Cost/Incentive
Onsite Pharmacy	Full service Walgreens retail pharmacy.	Benefit-eligible employees and their covered dependents are eligible to use the onsite pharmacy	Located on the 2nd floor of the County Administration building. Open Monday - Friday, 7 AM - 5 PM. 602-283-9925 602-283-9934 (Fax)	Catalyst Rx Consumer Choice Plan: members receive a $25 deposit into their Level 1 pharmacy account when they get their first prescription filled. Available once per lifetime and can only be used at the onsite pharmacy for prescriptions. Catalyst Rx Co-insurance Plan: members save an additional 10% on generic medication and 5% on preferred brand medication when filling a 90-day prescription. This savings is realized when compared to the cost at another retail pharmacy but will not be realized if the member is paying the minimum copayment. Members paying the maximum co-pay of $36 for generic or $120 for preferred brand will save with the lower maximum of $28 for generic or $70 for preferred brand.
~ Miscellaneous ~				
Healthy Rewards	A discount program available through CIGNA that offers discounts on weight management and nutrition products and services; fitness equipment, clubs and programs; tobacco cessation program, alternative medicine services; mind/body programs; dental care; vitamins and health and wellness products.	Employees and their covered dependents enrolled in a County-sponsored CIGNA medical plan	Information available via **www.cigna.com** Type in Healthy Rewards in the search box	Product and service costs and discounts are available on the CIGNA Web site
~ Physical Activities ~				
Fitness Center	Located in the basement of the County Administration building; locker rooms with showers, weights and cardio equipment	All employees	Complete enrollment forms, located on the Fitness Center web page: **http://www.maricopa.gov/benefits/wellness/fitnesscenter.aspx** Once your forms have been processed your ID badge will provide you access to the Fitness Center.	No Cost
Fitness Center Orientation	Receive individual instruction on the exercise equipment and learn basic fitness routines.	All employees with Fitness Center access	Schedule an appointment with the Fitness Coordinator at 602-372-9297.	No Cost

Initiative	Description	Who is Eligible?	How to Access Services/Incentives	Cost/Incentive
Fitness Program Session	Receive personalized exercise routines and workout plans. (For the intermediate or advanced exerciser)	All employees with Fitness Center access	Schedule an appointment with the Fitness Coordinator at 602-372-9297.	No Cost
Beginners Fitness Class	Designed for employees looking to begin an exercise program, but don't know how to get started.	All employees with Fitness Center access	Schedule an appointment with the Fitness Coordinator at 602-372-9297.	No cost
Walking Program	Walking for Wellness! Form a group of 4 or more co-workers and designate a walk leader. Wellness Works will schedule a team meeting with your group.	All employees	Contact the Fitness Coordinator at 602-372-9297. All employees must sign a liability waiver to participate.	No Cost
Group Fitness Classes	Lunch time and after work classes for circuit training and body conditioning, are available in the Fitness Center and at various County sites with available space	For classes held in the Fitness Center, for all employees with Fitness Center access For classes at other County sites, employees must sign a liability waiver to participate Classes are available at various County sites with available space	See Weekly Wellness Activities for scheduled classes or contact the Fitness Coordinator at 602-372-9297 to schedule group classes	No Cost
	Yoga and Tai Chi classes			Instructors charge an hourly rate. Employee cost per class is based on the number of employees enrolled in the class.
~ Pregnancy ~				
Dental Cleanings	A third dental cleaning is available to employees and their covered dependents as a way of supporting preventive care in the third trimester of pregnancy.	Employees or their covered dependent enrolled in Delta Dental.	Information available at **http://www.maricopa.gov/benefits/pdf/2010/Delta_Dental/third_cleaning.pdf**	Covered at 100% (deducted from the benefit maximum)
Dental Oral Health Integration Program (OHIP)	Women with periodontal gum disease may be at increased risk for pre-term babies and treatment for gum disease may reduce the likelihood of premature birth for women at risk. This program provides employees and/or dependents with 100% reimbursement of their coinsurance for certain related dental procedures (increased to 4 times per year). Please refer to OHIP program materials for covered dental services by medical condition.	Employees or their covered dependent enrolled in a County-sponsored CIGNA Dental and a CIGNA Medical plan.	Contact CIGNA Information available at **http://www.maricopa.gov/benefits/pdf/2011/CIGNA_Dental/oralhealth.pdf**	No Cost
Healthy Pregnancies, Healthy Babies Program	Comprehensive maternity support program that provides education, assessment and a care plan.	Employees or their covered dependent enrolled in a County-sponsored CIGNA medical plan	Enroll by calling 800-244-6224 and ask to enroll in the Healthy Pregnancies, Healthy Babies Program	No Cost; $150 incentive available at program completion if enrolled in first trimester or $75 if enrolled in second trimester

Initiative	Description	Who is Eligible?	How to Access Services/Incentives	Cost/Incentive
~ Stress Management ~				
Work Life Balance Classes:	Online classes or webinars offered through Magellan Health Services.	Employees enrolled in a County-sponsored CIGNA medical plan, except Choice Fund (for online classes or webinars)	Enroll via Pathlore on the EBC Internet. Class Search under "Employee Benefits"	No Cost
	1 hour classes presented by Magellan: Achieving Work-Life "Fit" Managing Stress in the Workplace Managing the Emotional and Financial Stress of Today's Economy Relaxation Techniques for Mind Body Wellness Take Control of Your Wellness for Total Health Opting For Happiness: A Lifestyle Choice The Best Ways To Stick with Your Nutrition Plans	All employees	Classes are available for departmental meetings or departmental/building events. Class request form must be completed by department director, manager or human resources liaison. To schedule a class, contact the Wellness Coordinator at 602-506-3758. Classes must be scheduled at least four weeks in advance. A minimum of 15 participants will be required to schedule a class.	
~ Tobacco Use ~				
Non-Smoker Reward for Additional Life Insurance	Non-smoking employees who have been smoke-free for at least 12 months receive a rate reduction on additional life insurance.	All benefit-eligible employees	If you have either never smoked or have not smoked for more than 12 consecutive months, you should review your coverage level options in the Benefit Enrollment System under the Additional Life page. The coverage level options listed below identify if you are eligible to receive the incentive for additional life insurance. Non-Tobacco User Tobacco User	Rate reduction for non-smokers when additional life insurance is purchased. Refer to life insurance rates in life insurance section.

Initiative	Description	Who is Eligible?	How to Access Services/Incentives	Cost/Incentive
Non-Tobacco User (saliva test) for Nicotine Presence	Voluntary saliva test that detects the use of nicotine. The test is completed by placing a swab in the mouth for 3-5 minutes.	Employees enrolled in a County-sponsored CIGNA medical plan. Only the employee completes the saliva test. To be eligible for the medical insurance premium reduction, the employee must complete and pass the saliva test. The employee and all covered dependents must be tobacco free for six consecutive months prior to the test. "Tobacco user" means the occasional or regular use of a tobacco product including, but not limited to, cigarettes, cigars, pipes, snuff, chewing tobacco and any other product containing tobacco product. Employees who do not provide accurate information and receive the premium reduction for which they are not eligible may be subject to disciplinary action up to and including termination.	Screening can be completed at the same time as your scheduled biometric screening appointment at Maricopa County worksite locations and at selected CIGNA HealthCare Centers during the mass biometric screening event (generally March – May), and on a walk-in first come, first served basis at CIGNA CareToday locations. Employees not participating in the biometric screening may complete the saliva test on a walk-in basis at Maricopa County worksite locations during the mass biometric screening event or at CIGNA CareToday locations. The EBC provides scheduling details during the mass biometric screening event around Open Enrollment (generally April – May). Additional information is available on the Employee Benefits home page under the "Wellness" tab. Saliva testing is available for new hires or others missing the mass event on a first come, first served basis at CareToday locations throughout the year. Respond to the Non-Tobacco User premium reduction options in the Benefit Enrollment System at time of enrollment. Following are the options : I completed the screening for the detection of nicotine presence. I am a user of tobacco products. A covered dependent is a user of tobacco products, but I am not. No one (employee or covered dependent(s)) uses tobacco products. I did not complete the screening for the detection of nicotine presence. I am a user of tobacco products. A covered dependent is a user of tobacco products, but I am not. No one (employee or covered dependent(s)) uses tobacco products.	Save up to $480 per year ($20 per pay period) on your County-sponsored medical insurance premium. If you or a covered dependent were a user of tobacco and quit, you will be eligible for this premium reduction when you have completed and passed the saliva test and all covered dependents in your household have been tobacco free for 6 consecutive months. Complete the Tobacco User Status form available on the Benefits Home page under General forms. The premium reduction is available on a prospective basis from the date the form is received in the Employee Benefits Division. Screenings completed Jan. 1 or thereafter qualify for the premium reduction for the next plan year.
Healthful Living Smoke Free Program	One-on-one monthly telephonic health coaching sessions for six months with one follow-up call nine months after enrollment. Enrollees receive step-by-step quitting advice, health education and motivational materials including a workbook to help track their smoke-free progress.	Employees and their dependents age 18 and above enrolled in either the Catalyst Rx Coinsurance or Consumer Choice Pharmacy plan.	Call 866-661-6781, Monday through Thursday 8:00 am to 11:00 pm, Friday 8:00 am to 9:00 pm or Saturday 9:00 am to 6:00 pm (EST) to enroll. Please mention you are registering for the Catalyst Rx Smoke Free program offered by Maricopa County.	No Cost; OTC and prescription smoking cessation medications are covered 100% up to $500/plan year. Products are limited to a 30-day supply of smoking cessation product per coaching call.

Initiative	Description	Who is Eligible?	How to Access Services/Incentives	Cost/Incentive
Quit Tobacco Program	Six-week program provided in a group class setting at worksite locations.	Employees and their covered dependents enrolled in a County-sponsored CIGNA medical plan.	Call 602-372-7272 to enroll or email **tamifreed@mail.maricopa.gov**	Following your first class, the Tobacco Cessation Specialist will notify the Employee Benefits Division to authorize a one-month supply of the tobacco cessation product, if you are enrolled in a Catalyst Rx Pharmacy plan. Those enrolled in the Choice Fund Medical plan will need to pay full price for cessation products and then submit a receipt to the Employee Benefits Division for reimbursement. After you complete 3 classes, the Tobacco Cessation Specialist will notify the Employee Benefits Division to authorize tobacco cessation products for the remainder of the plan year (July 1 – June 30) until you reach your $500 cap. Those enrolled in the Choice Fund Medical plan will need to pay full price for products and then submit a receipt to the Employee Benefits Division for reimbursement. NOTE: The $500 per plan year limit is per participant and includes any funds already used in the Smoke Free telephonic health coaching program. Participants dropping out of the Quit Tobacco Program can re-enroll at any time, however, the $500 limit continues to apply throughout the plan year.

Initiative	Description	Who is Eligible?	How to Access Services/Incentives	Cost/Incentive
~ Weight Management ~				
Am I Hungry?	An 8-week workshop that teaches you how to be in charge of your eating instead of feeling out of control; eat the foods you love without overeating and without guilt, and eat healthier foods without depriving or restricting yourself.	Employees enrolled in a County-sponsored CIGNA medical plan	Enroll via Pathlore Course Code: LIF160 Watch Weekly Wellness Activities for class schedule.	No Cost
Nutritional Counseling	3 self-referral nutritional counseling visits with a registered dietician at designated CIGNA HealthCare facilities.	Employees and their covered dependents enrolled in a County-sponsored CIGNA Medical plan.	Nutritional counseling is available at select CIGNA HealthCare facilities. Call 623-876-2555 for general information.	For nutritional counseling visit, your non-CCN specialist office visit co-payment is required.
Waisting Away Incentive Program	Program offering a reward for losing weight when attending Weight Watcher (WW) classes. (Does not apply to participants in the online WW Program.)	Employees and their covered dependents age 10 and up enrolled in a County-sponsored CIGNA medical plan	When you have completed the program requirements go to: **http://www.maricopa.gov/benefits/wellness/ww.aspx** Must provide a copy of your paid receipt for the WW 10-week program along with a copy of the WW booklet showing attendance dates, and your weight recorded for each week you attended the Weight Watchers class.	Attend 8 of 10 WW classes in a 10-week period and lose 10 pounds to receive $120 reimbursement via paycheck. NOTE: Reimbursement is considered taxable income.
Weight Watchers at Work	10-week program that focuses on portion control, mindful eating and lifestyle changes.	All employees	Enroll through Weight Watchers 602-248-0303 Watch Weekly Wellness Activities for worksite locations.	$120 per each 10-week session. Costs may increase without notice.
Weight Management Classes:	1 hour classes presented by CIGNA Health Education. Eat the Foods You Love and Still Lose Weight-*Part 1 and 2 (two 1-hour seminars)* Jump Start Your Weight Loss The Keys to Long Term Weight Loss Sensible and Slimming Snacks Top 10 Lessons From Those Who Kept the Weight Off Weight Management and Menopause Yoga and Weight Loss 25 Tips to Jump Start Your Weight Loss	All employees	Classes are available for departmental meetings or departmental/building events. Class request form must be completed by department director, manager or human resources liaison. To schedule a class, contact the Wellness Coordinator at 602-506-3758. Classes must be scheduled at least six weeks in advance. A minimum of 15 participants will be required to schedule a class.	No Cost

Initiative	Description	Who is Eligible?	How to Access Services/Incentives	Cost/Incentive
Nutrition/Food and Cooking Classes:	1 hour classes presented by CIGNA Health Education. A New Approach to Nutrition Busted! The Truth About Nutrition Myths Eat Well, Live Better Fad Diets Fueling Your Body For a Good Competition Mindful Eating: Controlling Food Intake Simplify…Substitute...Satisfy Supermarket Survival Dietary Supplements Caffeine: How Much is Too Much Don't Skip Breakfast! Food Additives: I'm Eating What? Healthy Substitutes Is Your Food Safe? Food Safety 101 Lunch: Eat Up for Energy! Mood Food Ten Foods You Oughta Eat What's For Dinner? The Best Ways to Stick with Your Nutrition Plan	All employees	Classes are available for departmental meetings or departmental/building events. Class request form must be completed by department director, manager or human resources liaison. To schedule a class, contact the Wellness Coordinator at 602-506-3758. Classes must be scheduled at least six weeks in advance. A minimum of 15 participants will be required to schedule a class.	No Cost
Heart Disease/ Hypertension Classes:	1 hour classes presented by CIGNA Health Education. Heart Attack and Stroke Raising a Heart Healthy Family Take It To Heart Under Pressure Heart Failure 101	All employees	Classes are available for departmental meetings or departmental/building events. Class request form must be completed by department director, manager or human resources liaison. To schedule a class, contact the Wellness Coordinator at 602-506-3758. Classes must be scheduled at least six weeks in advance. A minimum of 15 participants will be required to schedule a class.	No Cost

Initiative	Description	Who is Eligible?	How to Access Services/Incentives	Cost/Incentive
Cholesterol Classes:	1 hour classes presented by CIGNA Health Education. Do You Know Your Numbers? Supplements and Cholesterol: What May Be Helpful and What Could Be Harmful?	All employees	Classes are available for departmental meetings or departmental/building events. Class request form must be completed by department director, manager or human resources liaison. To schedule a class, contact the Wellness Coordinator at 602-506-3758. Classes must be scheduled at least six weeks in advance. A minimum of 15 participants will be required to schedule a class.	No Cost
Miscellaneous Classes:	1 hour classes presented by CIGNA Health Education. Oh, My Aching Back! Reducing Your Risk of Cancer Oh, My Aching Head! Sleep: Up All Night Goal Setting: Resolution Revolution Holiday Survival Ultimate Balance Act	All employees	Classes are available for departmental meetings or departmental/building events. Class request form must be completed by department director, manager or human resources liaison. To schedule a class, contact the Wellness Coordinator at 602-506-3758. Classes must be scheduled at least six weeks in advance. A minimum of 15 participants will be required to schedule a class.	No Cost
~ Health Screenings ~				
Biometric Screening	Voluntary, brief confidential personal health history, measurements of height, weight, waist circumference, body fat composition, non-fasting or fasting cholesterol and glucose levels (finger stick), and blood pressure. Based on the results of your Biometric Screening, a health coach, provided by Magellan Health Services, may call you to work with you one-on-one to help you identify and achieve your health and wellness goals. See "Health Coaching" initiative on this table. You'll receive a personalized results booklet at the end of your screening that a wellness coach will review with you. Take it to your next doctor's visit, or use it to ask your doctor questions to learn more about your health and to make simple changes to improve your health status.	Employees enrolled in a County-sponsored CIGNA medical plan	Screenings are performed by appointment only at several Maricopa County worksite locations and at selected CIGNA HealthCare facilities during the mass biometric screening event (generally March - May). During this time, go online to **www.cignascreenings.com/maricopa** or call 800-694-4982 Monday - Friday 8 AM - 6 PM MST to schedule your appointment. The EBC provides scheduling details during the mass event around the Open Enrollment period. Additional information is available on the Employee Benefits Home page or under the "Wellness" tab. Screenings are available for new hires or others missing the mass event on a first come, first served basis at CareToday clinics throughout the year.	No Cost; You can save $5 per pay period up to a total of $120 annually per plan year. If you are newly eligible to receive the premium reduction, you must complete your screening within 45 calendar days of your medical benefit effective date for the premium reduction to be retroactive to such date. Otherwise, the premium reduction will be available on a prospective basis, the next pay period after completion. Screenings must be completed each year in order to continue receiving the premium reduction for the next plan year. Screenings completed Jan. 1 or thereafter qualify for the premium reduction for the next plan year.

Initiative	Description	Who is Eligible?	How to Access Services/Incentives	Cost/Incentive
Blood Pressure Screening	Blood pressure check at the onsite Walgreens Pharmacy, 301 W. Jefferson Street.	All employees	Available on a walk-in basis the third Friday of every month from 8:00 am to 3:00 pm.	No Cost
Blueprint for Wellness	30+ fasting lab tests and a confidential personal lab report.	Employees enrolled in a County-sponsored medical plan who have not participated in a Blueprint event in the last 12 months	The screenings are only offered between July and December. By appointment only; scheduled online through Blueprint for Wellness. Watch for Weekly Wellness Activities for screening schedule.	No Cost
Health Assessment	Voluntary online questionnaire from the University of Michigan regarding your health and lifestyle. Confidential results are calculated and provide you with an assessment of your health status. The questionnaire asks information regarding biometric measures such as weight, blood pressure and cholesterol levels so it is advisable to take the assessment soon after participating in the Biometric Screening initiative. Based on your responses, you will also receive an invitation to participate in an online coaching program. Print a summary of your health report to take to your next doctor's visit, or use it to ask your doctor questions to learn more about your health and to make simple changes to improve your health status.	Employees enrolled in a County-sponsored CIGNA medical plan	Available online at **www.mycigna.com**; Registration instructions and directions on how to access the health assessment tool are available on Employee Benefits Home page or under the "Wellness" tab.	No Cost; You can save $5 per pay period up to a total of $120 annually per plan year. If you are newly eligible to receive the premium reduction, you must complete your assessment within 45 calendar days of your medical benefit effective date for the premium reduction to be retroactive to such date. Otherwise, the premium reduction will be available on a prospective basis, the next pay period after completion. Assessments must be completed each year in order to continue receiving the premium reduction for the next plan year. Assessments completed Jan. 1 or thereafter qualify for the premium reduction for the next plan year.
Health Coaching	Voluntary coaching program for employees with certain risks identified through the Biometric Screening Program and/or Health Assessment; help with developing a personal action plan, overcoming personal challenges, and staying motivated with one-on-one support and encouragement.	Employees who participated in the Biometric Screening Program and/or Health Assessment who have certain risk factors	Health Coach will contact you directly by phone	No Cost

Initiative	Description	Who is Eligible?	How to Access Services/Incentives	Cost/Incentive
One-on-One Health Education Session	Visit one-on-one for 30 minutes with a health educator to help plan out a healthy lifestyle change. The health educators can assist with all areas of wellness from nutrition and fitness to stress management and smoking cessation.	Employees enrolled in a County-sponsored CIGNA medical plan	Enroll via Pathlore. Watch Weekly Wellness Activities for class schedule.	No Cost
Mobile Onsite Mammography (MOM)	Mammography screening.	Annually for female employees at least 40 years of age enrolled in a County-sponsored CIGNA medical plan; other insurance also accepted	By appointment through MOM 480-967-3767 **www.mobileonsitemammography.com** Watch for Weekly Wellness Activities for scheduled events and registration information.	No Cost
Prostate Onsite Project (POP)	Prostate Antigen Specific (PSA) blood test and digital rectal exam.	Annually for male employees at least 40 years of age enrolled in a County-sponsored CIGNA medical plan	By appointment through POP 480-964-3013 **www.prostatecheckup.com** Watch for Weekly Wellness Activities for scheduled events and registration information.	No Cost
Ultrasound Screening	Ultrasound screenings for osteoporosis/bone density, carotid artery, abdominal aortic aneurysm (AAA) and peripheral arterial disease	All employees	By appointment through Health First by calling 800-209-4848 Watch for Weekly Wellness Activities for scheduled events and registration information.	Any 3 tests - $95 Prices are subject to change without notice.
Skin Cancer Screening	Site specific skin checks	Employees enrolled in a County-sponsored CIGNA medical plan	By appointment only. Watch for Weekly Wellness Activities for scheduled events and registration information.	No Cost

Enrollment Checklist

☐ 1. Complete the Worksheet that was mailed to your home address by noting your benefit enrollment elections. This will help you to complete your online enrollment quickly.

- Please note that after 15 minutes of inactivity in the Benefit Enrollment System, you will be logged out. Your changes will be saved as long as you go back and finish your elections by 8 PM MST on the same day.

☐ 2. If not previously registered with the ADP Self-Service Portal, type **https://portal.adp.com** in the Internet Explorer browser address bar. Click on the link "First Time Users Register Here." Then click on the "Register Now" button and follow the prompts.

- The registration pass code for Maricopa County is MCAZ-PRISM09 (this pass code is not case sensitive and contains a zero).
- During the registration process you will set your own password and answer security questions. No one at the County will know your password, so store it in a secure location. Password resets are done by calling 602-506-HELP.

☐ 3. Log on to the portal before the end of the enrollment period specified on your Worksheet.

☐ 4. Click on the "Benefits" tab at the top of the portal page and then click on "Welcome" on the drop-down list.

☐ 5. On the next page, click on the "Benefit Enrollment System" link at the bottom of the left-hand column.

☐ 6. Read the "Welcome" page and press "Continue".

☐ 7. Read the instructions for completing each page, located in the left-hand column.

☐ 8. At the Main Menu, click on the Newly Eligible or other appropriate link.

☐ 9. Review your Personal Information. If incorrect, contact Employee Records at: (602) 506-3519

☐ 10. The Benefit Enrollment System is programmed to take you through each available election. Through this Top-Down process you will:

a. Review your dependents. Dependents must be listed first in order to be enrolled in a benefit or to enroll for spouse or child life insurance coverage.
b. Update your beneficiary information for life insurance coverage.
c. Review and update your benefit elections. **Make sure that dependents are enrolled by checking the box next to their names for each benefit.**
d. Enroll in the Annual Account elections (for flexible spending accounts and/or health savings account contributions).
e. Click on the Submit button on the Benefit Summary page to save your elections.
f. Read and agree to the Certification Statement.
g. Enter your email address to receive an email acknowledgement that you completed enrollment or click Cancel to pass through this question.
h. Print your Confirmation page for your records.
i. When you see the Thank You page, your enrollment has been completed.

☐ 11. A Confirmation Statement will be mailed to your home address within the next 10 days.

☐ 12. Compare the Confirmation page you printed during the enrollment process with the Confirmation Statement you receive in the mail.

☐ 13. If the information on the Confirmation Statement is incorrect, contact the EB Division within 10 business days from the print date of your Confirmation Statement. Call 602-506-1010, press 2 and then 2 again.

For an illustrated step-by-step instruction go to:

http://www.maricopa.gov/benefits/pdf/2011/OE11/onlineNewHireEnrollmentSystem.pdf

Maricopa County Employee Benefits
301 W Jefferson St. Suite 3200
Phoenix, AZ 85003

2011 - 2012 Benefits Enrollment Worksheet

ENROLLMENT DEADLINE
07/29/2011

MCYWZS1
TU85 0001

Ima Sample
123 Anywhere St
Apt 1A
Sometown, AZ 85000

Printed: 08/08/2011
Event: New Hire
Employee ID: 811999999

Enrollment Instructions:

1. Review this Worksheet. You will be enrolled in the benefit coverage marked with a check (✓) unless you make a change.
2. Complete this Worksheet before you go online to make benefit changes.
3. Use the boxes on the left-hand side of the Worksheet to indicate the option code and cost for each benefit you select.
4. Enroll online at https://portal.adp.com by the enrollment deadline shown above.
5. You must register at https://portal.adp.com. Your registration pass code is MCAZ-PRISM09.
6. If you do not have access to a computer, check with your department HR Liaison for computer resources that will be available for your use.
7. Paper enrollment or late enrollment will not be accepted. Contact 602-506-1010, press 2 and then press 2 again if you have enrollment questions.
8. For information regarding the benefits offered, please visit www.maricopa.gov/benefits or the internal Intranet at http://ebo.maricopa.gov/ebi.
9. Review the *Know Your Benefits* booklet located on the Web site listed above.
10. This Worksheet represents all of your available options.

Dependent Information

You are responsible for adding only eligible dependents and updating any incorrect or incomplete dependent information. The following list displays all individuals who are currently enrolled in benefits as your dependent.

No.	Name	Relationship*	Birth Date	Sex	Student	Disabled	Medical	Dental	Vision
0	Ima Sample	EE	06/27/1956	F			Y	Y	Y
1	Hubby Sample	SP	01/07/1955	M			Y	Y	Y

*Relationship codes are:
EE = Employee, SP = Spouse, CH = Child, SC = Step-Child, LG = Legal Guardian, CO = Court-order, BN = Beneficiary

Medical

Your Choice
Option Code
Cost

Option Code	Option Name	Coverage Category/Cost Per Pay Period: Employee Only**	Employee plus Spouse**	Employee plus Child(ren)**	Employee plus Family**
✓001	**CIGNA Medical Group High ***	$37.39	✓$57.14	$44.92	$76.87
002	CIGNA Medical Group Low *	$34.76	$48.45	$40.10	$61.42
003	Open Access Plus In-Network	$46.65	$107.10	$84.93	$144.37
004	Open Access Plus High	$47.55	$107.64	$86.51	$146.94
005	Open Access Plus Low	$34.62	$48.58	$40.29	$62.34
006	Choice Fund - HSA	$30.00	$30.00	$30.00	$30.00
000	Waived				

* You are required to provide the code or number found in the Online Provider Directory for the Primary Care Provider at the time you enroll. Instructions are located in the "How to Look Up a Provider Online" section of the *Know Your Benefits* booklet or you can contact the vendor.

** Cost per pay period does not reflect premium reductions for Biometric Screening, Health Assessment and/or Non-Tobacco Use.

Biometric Screening Premium Reduction

Employees (not including dependents) enrolled in a County-sponsored medical plan who participate in the annual Biometric Screening will save up to $120 per plan year on their medical insurance premium. The biometric screening provided by CIGNA Onsite Health consists of completing a brief personal health history as well as having your measurements taken for height, weight, blood pressure, waist circumference, body fat composition, cholesterol, and glucose levels.

Benefits Enrollment Worksheet

Health Assessment Premium Reduction

Employees (not including dependents) enrolled in a County-sponsored medical plan who participate in the annual Health Assessment will save up to $120 per plan year on their medical insurance premium. The Health Assessment is available online through www.mycigna.com and consists of a series of questions about your health and lifestyle. Your confidential responses are then assessed by the online tool to determine your health risks.

Non-Tobacco User Premium Reduction

When employees and all of their dependents enrolled in a County-sponsored medical plan do not use tobacco products (regularly or occasionally) for the past 6 consecutive months, and if the employees take the saliva test that detects nicotine presence and have a negative result, they will save up to $480 per plan year on their medical insurance premium. Tobacco use includes cigarettes, cigars, pipes, snuff, chewing tobacco and any other product containing tobacco during the last six consecutive months.

Health Savings Account

When you enroll in the Choice Fund medical plan, you may contribute to your Health Savings Account on an annual basis. You can contribute up to $3,050 (individual) or $6,150 (family) to your account for calendar year 2011 minus the amount contributed by Maricopa County. If you are 55 or above, you can contribute an additional $1,000. Unused balances remain in your account.

Pharmacy

Coverage Category/Cost Per Pay Period

Your Choice
Option Code
Cost

Option Code	Option Name	Employee Only	Employee plus Spouse	Employee plus Child(ren)	Employee plus Family
✓001	**Co-insurance Prescription Plan**	$5.57	✓**$11.03**	$8.29	$16.56
002	Consumer Choice Prescription Plan	$0.00	$0.00	$0.00	$0.00
003	Choice Fund HSA Prescription Plan	$0.00	$0.00	$0.00	$0.00
000	Waived Prescription				

Vision

Coverage Category/Cost Per Pay Period

Your Choice
Option Code
Cost

If you enroll in any County-sponsored medical plan, you must enroll in the vision plan (EyeMed with Med election). The County also offers this plan as a separate (stand-alone) vision plan for employees who choose to waive their medical benefits and wish to enroll in the vision plan (EyeMed no Med election).

Option Code	Option Name	Employee Only	Employee plus Spouse	Employee plus Child(ren)	Employee plus Family
✓001	**EyeMed (with Med election)**	$0.42	✓**$0.78**	$0.82	$1.20
002	EyeMed (no Med election)	$5.35	$10.10	$10.58	$15.53
000	Waived Vision				

Behavioral Health Coverage

The behavioral health coverage is provided as part of your enrollment in a County-sponsored medical plan and is provided to you at no cost. Enrollment is mandatory.

Dental

Coverage Category/Cost Per Pay Period

Your Choice
Option Code
Cost

Option Code	Option Name	Employee Only	Employee plus Spouse	Employee plus Child(ren)	Employee plus Family
001	Employers Dental Services *	$2.25	$4.27	$5.60	$6.43
✓002	**CIGNA Dental**	$7.34	✓**$16.19**	$17.51	$22.51
003	Delta Dental	$12.66	$27.94	$30.21	$38.85
000	Waived Dental				

* You are required to provide the code or number found in the Online Provider Directory for the Primary Care Provider at the time you enroll. Instructions are located in the "How to Look Up a Provider Online" section of the *Know Your Benefits* booklet or you can contact the vendor.

Enroll online at https://portal.adp.com by 07/29/2011

TUAS 0001 0204

Benefits Enrollment Worksheet

Additional Life Insurance

Coverage Category/Cost Per Pay Period

Your Choice
Option Code
Cost

Basic Life Insurance of 1X Annual Base Salary is provided to you at no cost. You may elect additional coverage from the following options:

Option Code	Coverage Level	Non Tobacco User	Tobacco User
001	1X Annual Base Salary	$8.97	$27.65
002	2X Annual Base Salary	$17.94	$55.30
✓003	**3X Annual Base Salary**	$26.91	✓**$82.95**
004	4X Annual Base Salary*	$35.88	$110.60
005	5X Annual Base Salary*	$44.85	$138.26
000	Waived Additional Life	$0.00	$0.00

* You must complete a Medical History Statement if you choose this Coverage Level. Please review enrollment information at https://portal.adp.com for details.

Additional Accidental Death and Dismemberment

Coverage Category/Cost Per Pay Period

Your Choice
Option Code
Cost

Basic Accidental Death and Dismemberment (AD&D) Insurance of 1X Annual Base Salary is provided to you at no cost. Accidental Death and Dismemberment coverage does not require Evidence of Insurability. You may elect any level from the following options:

Option Code	Coverage Level	Employee Only	Employee Plus Family
001	1X Annual Base Salary	$0.78	$1.37
002	2X Annual Base Salary	$1.56	$2.73
✓003	**3X Annual Base Salary**	$2.34	✓**$4.10**
004	4X Annual Base Salary	$3.12	$5.46
005	5X Annual Base Salary	$3.90	$6.83
000	Waived Additional AD&D	$0.00	$0.00

Spouse Life Insurance

Coverage Category/Cost Per Pay Period

Your Choice
Option Code
Cost

If there is not a spouse listed on file, the rates on this Worksheet will be based on the employee's age. Once your spouse is on file, the rates will be adjusted based on the spouse's age. The rates on the Confirmation Statement will be the adjusted rate. If you are married to a Maricopa County employee, you are not eligible to elect Spouse Life coverage.

Option Code	Coverage Level	Cost Per Pay Period	Option Code	Coverage Level	Cost Per Pay Period
001	$10,000	$2.97	007	$70,000*	$20.79
✓002	**$20,000**	**$5.94**	008	$80,000*	$23.76
003	$30,000	$8.91	009	$90,000*	$26.73
004	$40,000	$11.88	010	$100,000*	$29.70
005	$50,000	$14.85	000	Waived Spouse Life	
006	$60,000*	$17.82			

* You must complete a Medical History Statement if you choose this Coverage Level. Please review enrollment information at https://portal.adp.com for details.

Enroll online at https://portal.adp.com by 07/29/2011

TU85 0001 0304

Benefits Enrollment Worksheet

Child Life Insurance

Coverage Category/Cost Per Pay Period

Your Choice
Option Code
Cost

If you are married to a Maricopa County employee, your dependent child(ren) can only be covered by one of you under this group policy.

	Option Code	Coverage Option	Cost Per Pay Period
	001	$5,000	$0.25
	002	$10,000	$0.50
	003	$15,000*	$0.75
	004	$20,000*	$1.00
✓	**000**	**Waived Child Life**	

* You must complete a Medical History Statement if you choose this Coverage Level. Please review enrollment information at https://portal.adp.com for details.

Short Term Disability

Coverage Category/Cost Per Pay Period

Your Choice
Option Code
Cost

You may only enroll, increase, decrease or drop coverage from the Short-Term Disability Plan during Open Enrollment. If you increase your coverage level and you have a pre-existing condition, your benefit payment will be based on the lower benefit coverage level for 12 months following the increase.

Option Code	Coverage Level	Cost Per Pay Period	Option Code	Coverage Level	Cost Per Pay Period
001	40% STD Coverage	$8.64	✓**003**	**60% STD Coverage**	**$19.06**
002	50% STD Coverage	$12.21	000	Waived STD Coverage	

Health Care Flexible Spending Account

Annual Goal

(Pre-Tax Contribution)

When you enroll in the Health Care Flexible Spending Account, you may contribute from $26.00 to $5,200.00 for the plan year. The amount you elect will be divided by the number of pay periods in the plan year and taken from each paycheck.

You will default to no contribution if you do not make an election.

Dependent Care Flexible Spending Account

Annual Goal

(Pre-Tax Contribution)

When you enroll in the Dependent Care Flexible Spending Account for day care expenses, you may contribute from $26.00 to $5,000.00 for the plan year. The amount you elect will be divided by the number of pay periods in the plan year and taken from each paycheck. You are not eligible to enroll if your dependent child is 13 or older.

You will default to no contribution if you do not make an election.

Employee Assistance Program

The Employee Assistance Program is provided to you at no cost.

Group Legal Services

Coverage Category/Cost Per Pay Period

Your Choice
Option Code
Cost

	Option Code	Coverage Option	Cost Per Pay Period
	001	METLAW Group Legal Services	$7.87
✓	**000**	**Waived Group Legal**	

ID Cards

- CIGNA medical plan ID cards are issued to all new enrollees. CIGNA issues an individual ID card for each enrollee (insured employee and dependent). Each person is identified with an individual person code. Temporary ID cards are available on **www.mycigna.com**.

  The CIGNA medical ID card for the Choice Fund medical plan is used to receive medical, pharmacy and behavioral health services. The CIGNA ID cards for the other medical plans (CMG High, CMG Low, OAPIN, OAP High and OAP Low) are only used to receive medical services since pharmacy coverage is available through Catalyst Rx and behavioral health coverage is available through Magellan.

- Catalyst Rx pharmacy plan ID cards are issued to all new enrollees for the Co-insurance and Consumer Choice plans. There is one ID card per family that lists the insured employee and all dependents. Each person is identified with an individual person code. Temporary ID cards are available on **www.walgreenshealth.com**.

- There are no personalized ID cards for the CIGNA Dental plan. To print an ID card, go to the EB Home page, click on the Dental tab, then under the CIGNA Dental heading, click on the link CIGNA Dental ID Card.

- Delta Dental plan ID cards are issued to all new enrollees. ID cards are located on the back cover of the Delta Dental Summary of Benefits booklet mailed to your home address shortly after enrollment.

- Employers Dental Services ID cards are issued to all new enrollees. Two ID cards are issued in the employee's name and can be used by all enrolled dependents. Members are not required to show an ID card when seeking services because the EDS dentists receive a roster on the 1st and 15th of each month and all members assigned to that dentist are listed on the roster.

- EyeMed Vision issues ID cards to all new enrollees in the name of the insured. Additional cards may be printed from their Web site at **www.eyemedvisioncare.com**.

- Health Care Flexible Spending Account (FSA) debit cards are issued to all new enrollees. If you need additional debit cards for family members, you must complete a debit card request form available at **www.flexdirect.adp.com**.

  Employees re-enrolling in the Health Care FSA during Open Enrollment are not issued new debit cards. Their debit card is automatically reloaded with their new annual election amount at the beginning of the next plan year.

- There are no personalized ID cards for the Employee Assistance Program (EAP), administered by Magellan Health Services.

  Wallet cards for the Employee Assistance Program (EAP) are located on the EAP page. Go to the EB Home page, click on the Behavioral Health/EAP tab, then under the EAP heading click on the link to the EAP page. Or us the address below:
  http://ebc.maricopa.gov/ehi/pdf/2011/EAP/eapbrochure.pdf.

  There are no personalized ID cards for the behavioral health/substance abuse benefit, administered by Magellan Health Services. However, the phone number on the EAP wallet card described above should be used to access these benefits.

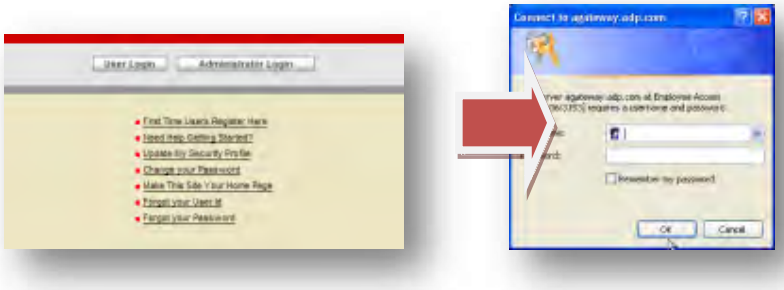
- There are no personalized ID cards for the MetLaw Group Legal plan. Wallet cards for this plan are located on MetLaw brochure. The brochure is available on the EB Home page by clicking on the Voluntary Benefits tab, then scrolling down to the Hyatt Legal Plans section and clicking on the MetLaw brochure.

- There are no ID cards for Short-term Disability Benefits.

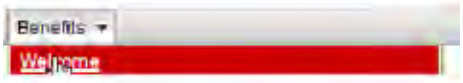
1. Complete the Worksheet that was mailed to you by noting your benefit elections. This will help you to complete your online enrollment quickly.
    a. Please note that after 15 minutes of inactivity, you will be logged out of the Benefit Enrollment System. Your changes will be saved as long as you go back and finish your elections by 8 PM MST on the same day.

2. If not previously registered with the ADP Self-Service Portal, type https://portal.adp.com in the Internet Explorer browser address bar. Click "Enter" or "Go".

Click on the link "First Time Users Register Here". Then click on the "Register Now" button and follow the prompts.
    a. The registation passcode is **MCAZ-PRISM09** (the last two digits are the numbers zero and nine).
    b. During the registation process you will set your own password and answer security questions.

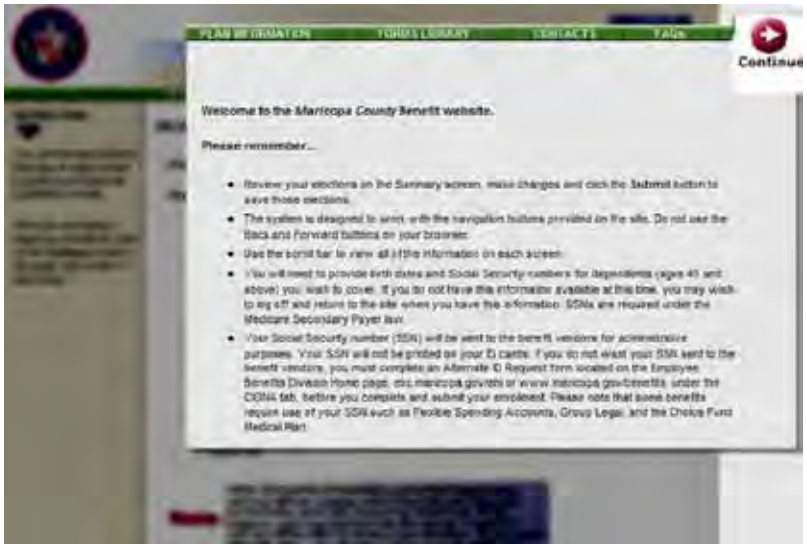


3. Once you are logged in, click on the "Benefits" tab then click on the "Welcome" link.

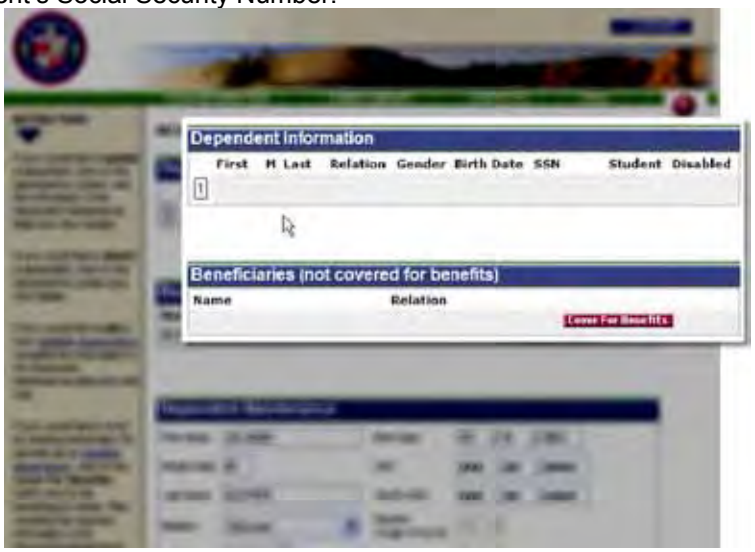


4. When the new page opens, click on the "Benefit Enrollment System" link.

5. At the Welcome Page, click “Continue”



6. Use the Dependent Maintenance Screen to input your dependent information.
   a. Enter your dependent’s name, relation, gender and date of birth.
   b. Enter your dependent’s Social Security Number.



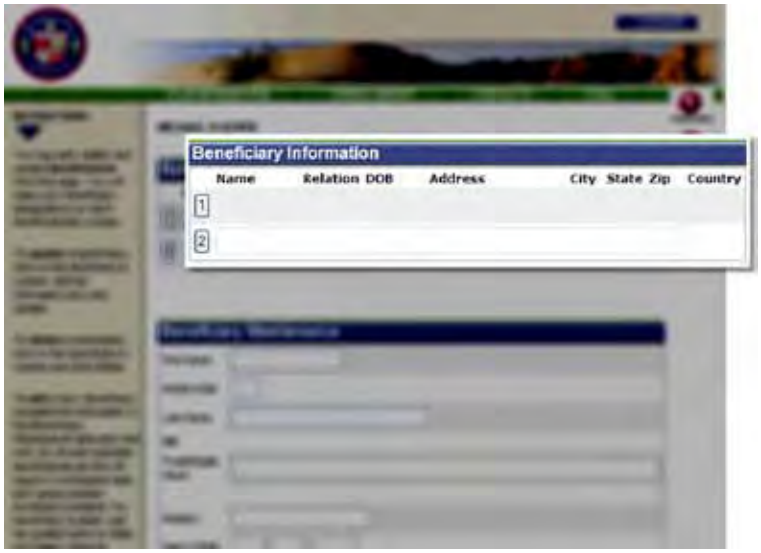
The Medicare Secondary Payer Mandatory Insurer Reporting Requirements of Sect 111 of the Medicare, Medicaid, and Schip Extension Act of 2007 requires the collection and reporting of the Social Security Number (or Medicare Health Insurance Claim Number “HICN”) from covered individuals as listed below:

   i. employees and covered family members age 45 to 64,
   ii. employees and covered spouses age 65 and older,
   iii. employees and covered dependents who receive kidney dialysis or have a kidney transplant, and
   iv. any covered individual that the plan sponsor knows to be entitled to Medicare.

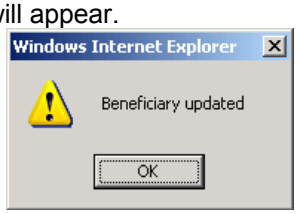
   c. Indicate the disabled status of your dependent.

d. When finished inputting your dependent's information, click the "Add" button. A warning message will pop up to advise you that your dependent is added but not yet enrolled in coverage. When all dependents have been added, click "Continue".

7. Beneficiary Information Update
   a. The Beneficiary Maintenance Screen allows you to input your beneficiary information.



   b. Enter the name of each beneficiary. If your beneficiary is a Trust or Estate, enter the name of the Trust or Estate.
   c. Enter the Date of Birth for the beneficiary. NOTE: Do not add duplicate beneficiaries as this will result in inconsistent data and cause possible enrollment problems. If a beneficiary is listed, use the update button to make necessary changes.
   d. This screen requires entry of a relation. If using a Trust or an Estate, enter "Trust" or "Estate" in the relation field.
   e. Click the "Add" button to add the beneficiary.
   f. When successfully added, the following pop-up message will appear.



   g. When all beneficiaries have been added, click "Continue"

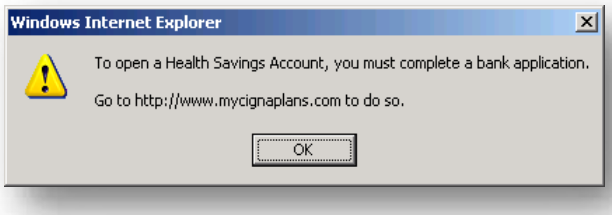
8. Beneficiary Designations
    a. The Beneficiary Designations Screen allows you to specify the percentage of your benefit being designated to each beneficiary.

    b. In this screen, you may also designate a beneficiary as a Primary or Contingent beneficiary.
    c. Click on the red “Beneficiary Information” button to amend or add other beneficiaries.
    d. When all designations have been updated, click “Continue”.
9. Medical Election
    a. This screen allows you to choose a medical plan for you and your dependents.

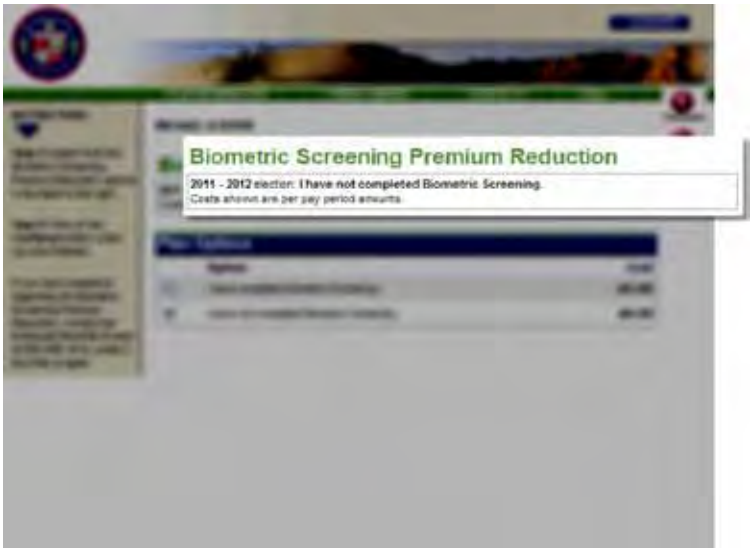
    Place a check mark in the box to the left of the name of each dependent you wish to cover. An unmarked box means that dependent will not be covered.

    b. When all designations have been updated, click “Continue”.
        i. NOTE: If you elected the Choice Fund Medical Plan with Health Savings Account and have not opened the Savings Account through JP Morgan Chase you must complete the online bank application located at

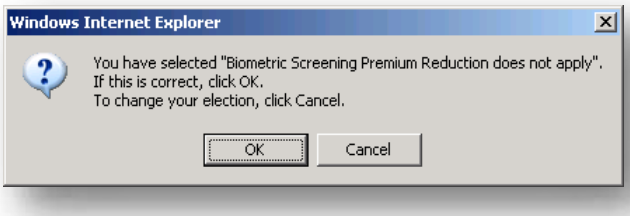
http://www.mycignaplans.com , UserID: maricopacounty2011, Password: cigna Otherwise, click “Ok”.



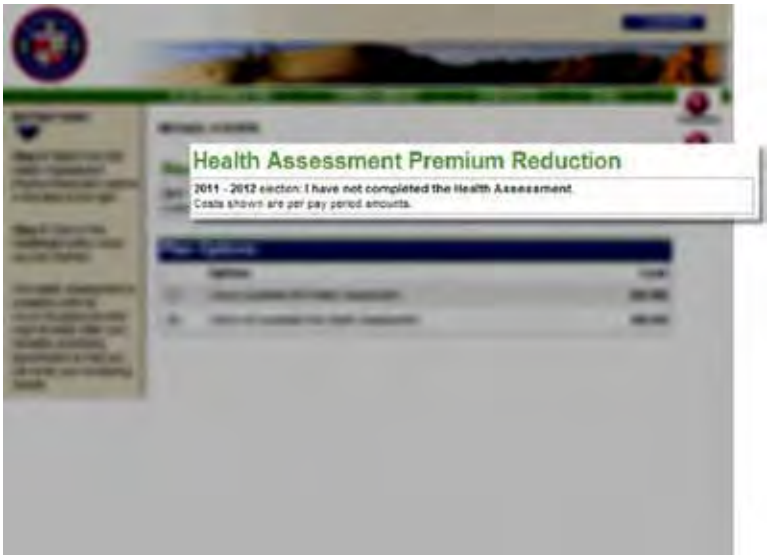
10. Biometric Screening Premium Reduction
    a. This screen allows you to indicate if you have completed the Biometric Screening in order to receive the Premium Reduction.



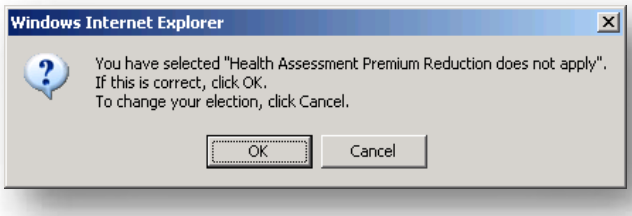
    b. Select the applicable Biometric Screening option.
    c. Click “Continue”.
    d. Click the “OK” button when the pop-up message to acknowledge your selection appears. To change your selection, click “Cancel” and make the change then click “Continue” again.



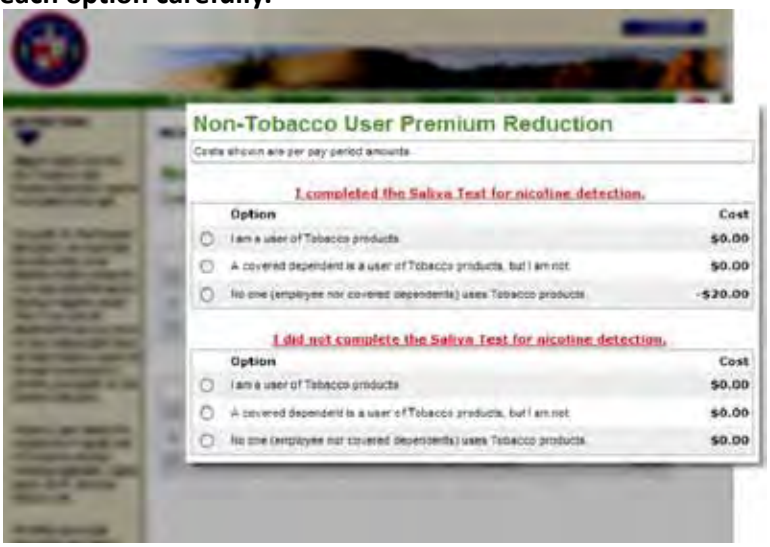
11. Health Assessment Premium Reduction
    a. This screen allows you to indicate if you have completed the Health Assessment in order to receive the Premium Reduction.



b. Select the applicable Health Assessment option.
c. When all selections have been updated, click “Continue”.
d. Click the “OK” button when the pop-up message to acknowledge your selection appears. To change your selection, click “Cancel” and make the change then click “Continue” again.

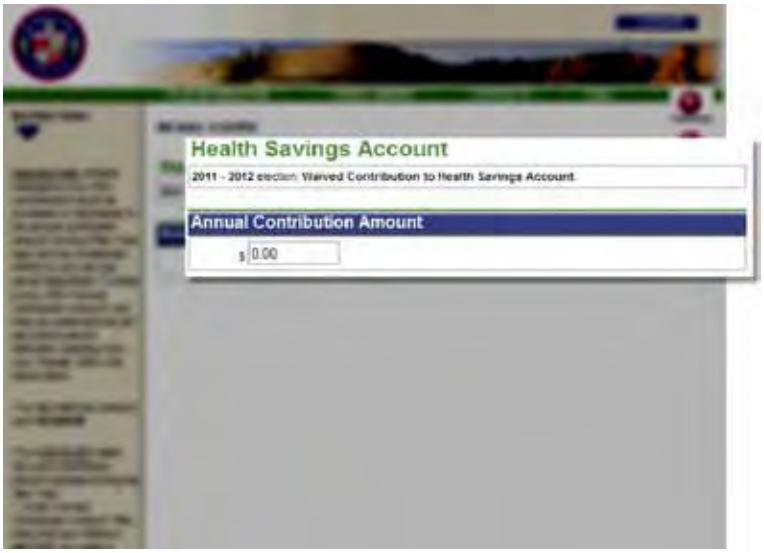


12. Non-Tobacco User Premium Reduction
    a. This screen allows you to indicate tobacco use status for you and your covered dependents. **Read each option carefully.**

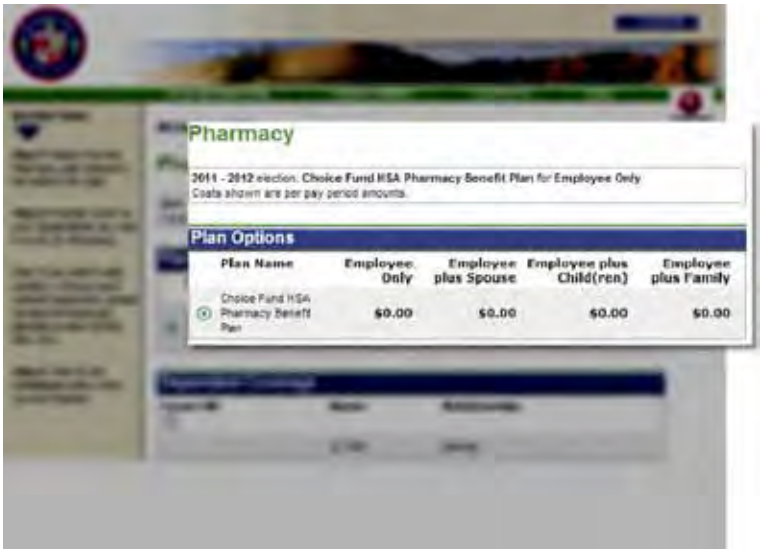


b. Select the appropriate section based on your participation in the Saliva Test and then complete the appropriate option for yourself and your covered dependents.
c. When all selections have been updated, click “Continue”.
d. Click the “OK” button when the pop-up message to acknowledge your selection appears. To change your selection, click “Cancel” and make the change then click “Continue” again.

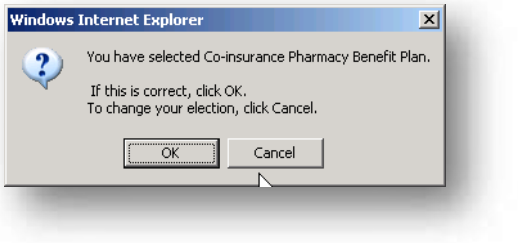
13. NOTE: If you elected the Choice Fund Medical Plan with Health Savings Account enter the annual dollar amount you wish to contribute to your Health Savings Account through payroll deductions. Otherwise, click “Continue”.



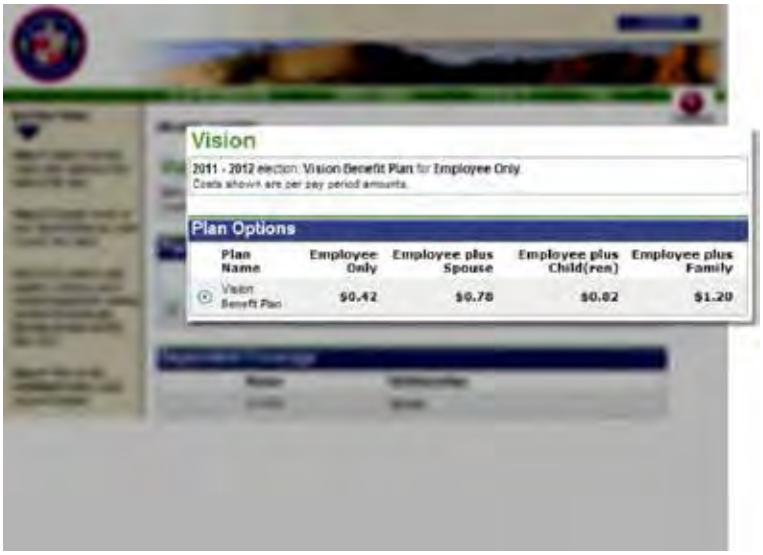
14. Pharmacy Election (If Choice Fund Medical Plan was chosen, click “Continue”.)
    a. This screen allows you to choose the pharmacy plan for you and your covered dependents.



b. When all selections have been updated, click “Continue”.
c. Click the “OK” button when the pop-up message to acknowledge your selection appears. To change your selection, click “Cancel” and make the change then click “Continue” again.



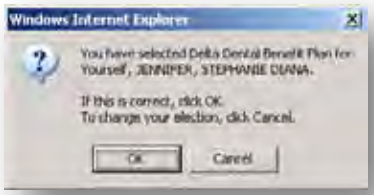
15. HICN Collection
    a. This screen allows you to indicate whether you or your dependents are enrolled in Medicare. Select the appropriate option for yourself and your dependents.
    b. Place a check mark in the box to the left of each dependent enrolled in Medicare.
    c. Click the "OK" button when the pop-up message to acknowledge your selection appears. To change your selection, click "Cancel" and make the change then click "Continue" again.
16. Enter your HICN
    a. If you and/or your covered dependent are enrolled in Medicare, enter the Health Insurance Claim Number (HICN) located on your Medicare card.
17. If you waived medical coverage, you may choose the vision plan option for yourself and dependents. Indicate your coverage level (e. g., Employee plus Family). Otherwise click "Continue".



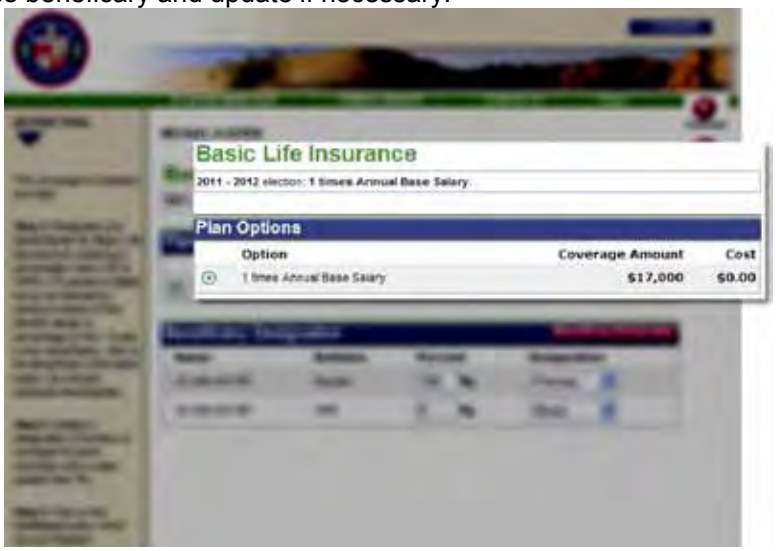
18. Review Behavioral Health coverage information and click "Continue". If you elected medical coverage, you are automatically enrolled in Behavioral Health coverage.
19. Dental Election
    a. This screen allows you to choose a dental plan for you and your dependents.

b. Select the appropriate plan option.

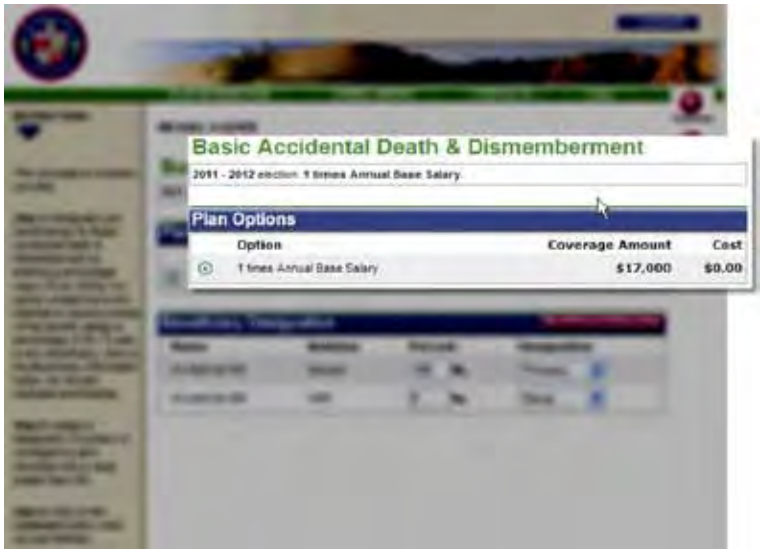
c. Place a check mark in the box to the left of the name of each dependent you wish to cover. An unmarked box means that dependent will not be covered.
d. When your selection has been updated, click “Continue”.
e. Click the “OK” button when the pop-up message to acknowledge your selection appears. To change your selection, click “Cancel” and make the change then click “Continue” again.



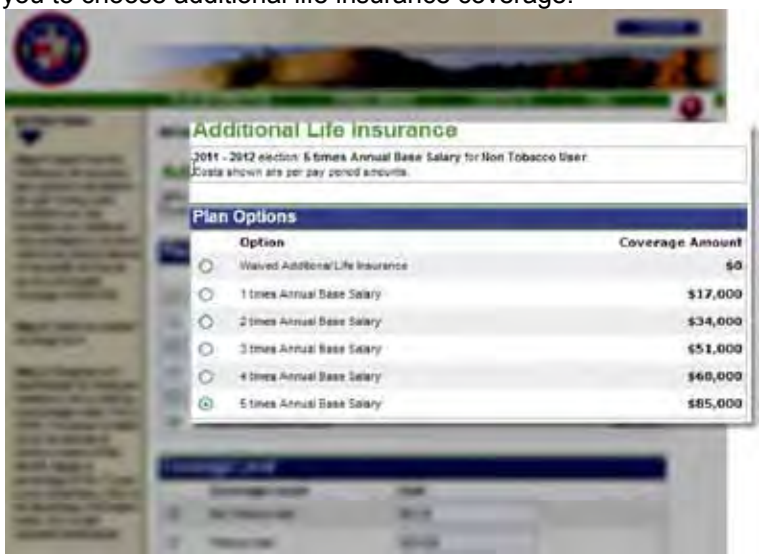
20. Review Basic Life Insurance beneficary and update if necessary.



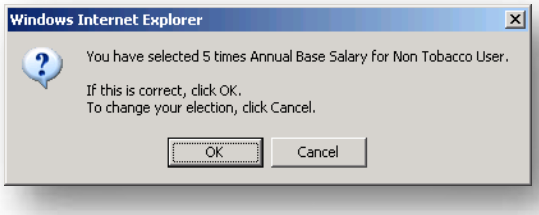
21. Review Basic Accidental Death and Dismemberment insurance beneficary and update if necessary.



22. Additional Life Insurance
    a. This screen allows you to choose additional life insurance coverage.

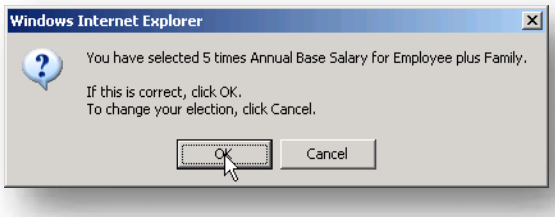


    b. Select the appropriate plan option in values ranging from one to five times your annual base salary and indicate your tobacco use status as this will determine your monthly cost for the insurance coverage.
    c. Review and update beneficiary designation if necessary.
    d. When all selections have been updated, click “Continue”.
    e. Click the “OK” button when the pop-up message to acknowledge your selection appears. To change your selection, click “Cancel” and make the change then click “Continue” again.

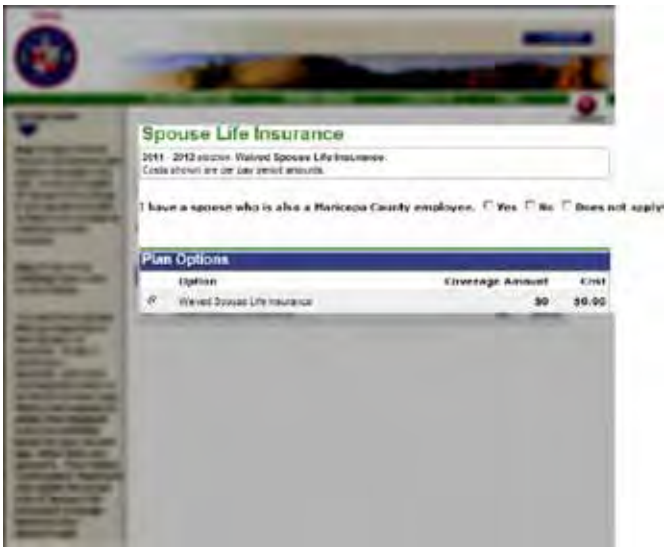


23. Accidental Death and Dismemberment Insurance
    a. This screen allows you to choose additional Accidental Death and Dismemberment coverage.

    b. Select the appropriate plan option in values ranging from one to five times your annual base salary, and select employee only or family coverage.
    c. Review and update beneficiary designation if necessary.
    d. When all selections have been updated, click “Continue”.
    e. Click the “OK” button when the pop-up message to acknowledge your selection appears. To change your selection click “Cancel” and make the change then click “Continue” again.

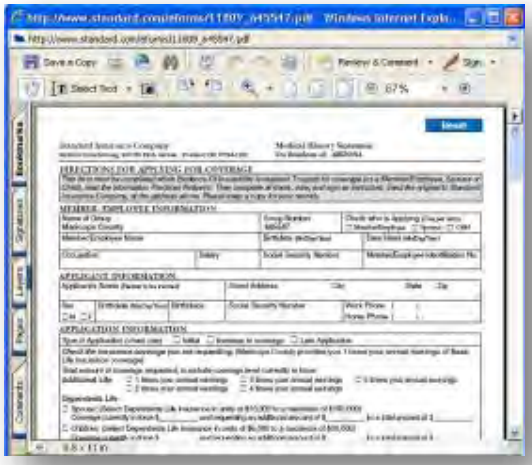


24. Spouse Life Insurance
    a. This screen allows you to choose spouse life insurance coverage.

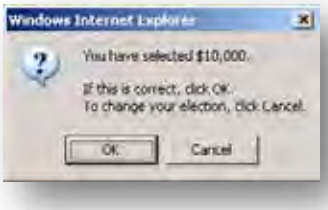


b. NOTE: A question regarding your spouse must be answered on this screen in order to continue.
c. Select the appropriate plan options in values ranging from $10,000 to $100,000.
d. Coverage amounts over $50,000 dollars require approval by the insurance company.

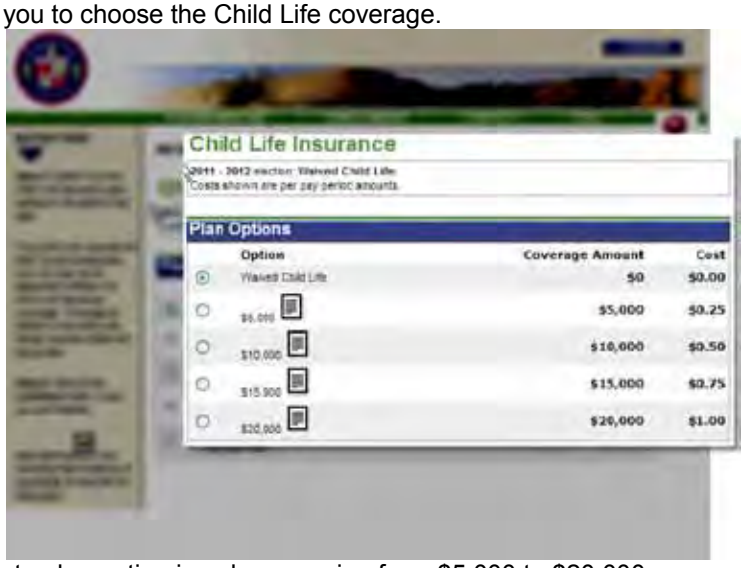
If evidence of insurability is required, complete and submit a Medical History Statement available at the link.



e. When all selections have been updated, click “Continue”.
f. Click the “OK” button when the pop-up message to acknowledge your selection appears. To change your selection, click “Cancel” and make the change then click “Continue” again.

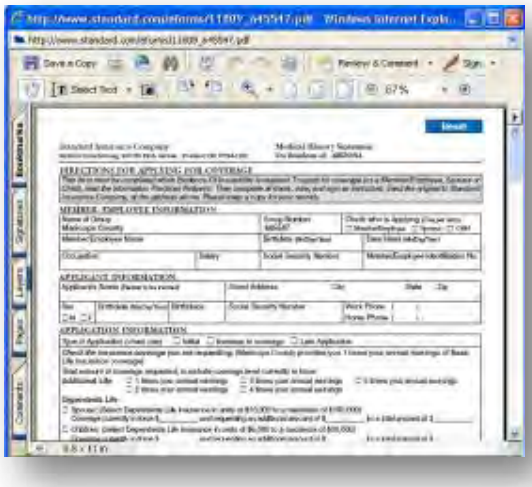


25. Child Life Insurance.
    a. This screen allows you to choose the Child Life coverage.



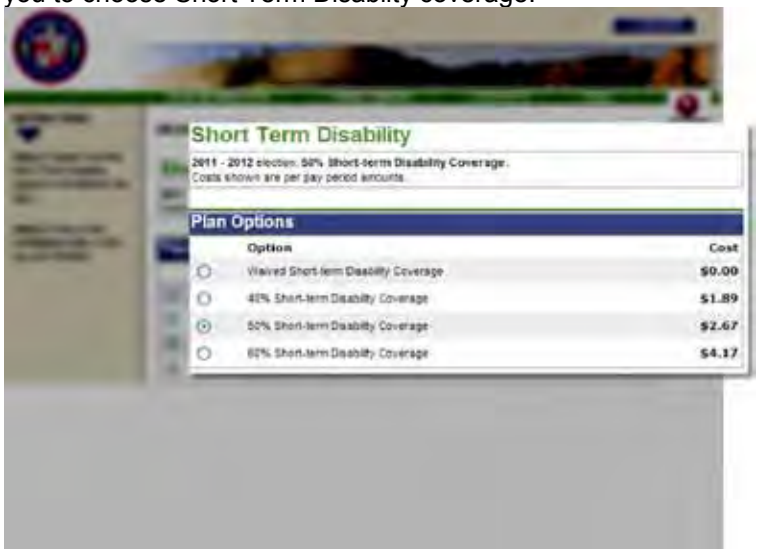
    b. Select the appropriate plan option in values ranging from $5,000 to $20,000.
    c. Coverage amounts over $10,000 require approval by the insurance company.

If evidence of insurability is required, complete and submit a Medical History Statement available at the link.



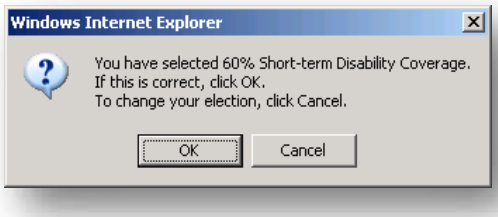
d. When all selections have been updated, click “Continue”.
e. Click the “OK” button when the pop-up message to acknowledge your selection appears. To change your selection click “Cancel” and make the change then click “Continue” again.

26. Short Term Disability
    a. This screen allows you to choose Short Term Disabilty coverage.



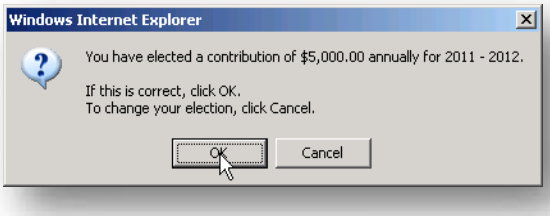
    b. Select the appropriate plan options in values ranging from 40% to 60% of base salary.

c. When all selections have been updated, click “Continue”.
d. Click the “OK” button when the pop-up message to acknowledge your selection appears. To change your selection click “Cancel” and make the change then click “Continue” again.

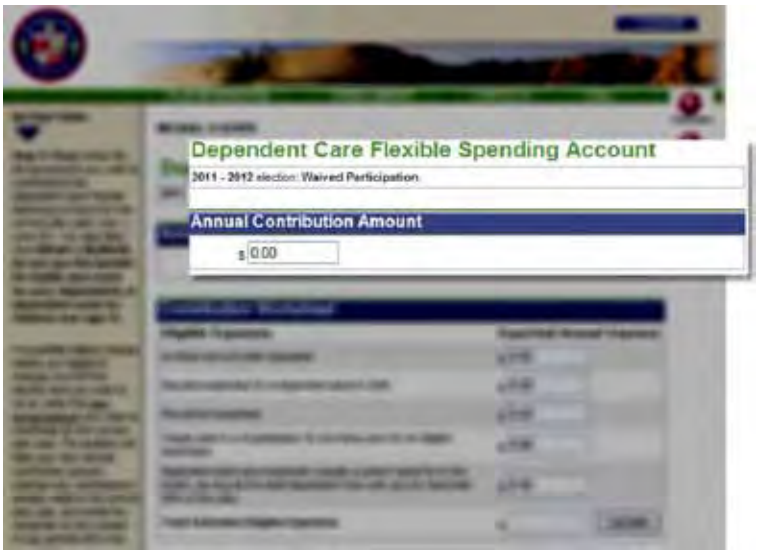


27. Health Care Flexible Spending Account
    a. This screen allows you to enroll in the Health Care Flexible Spending Account.

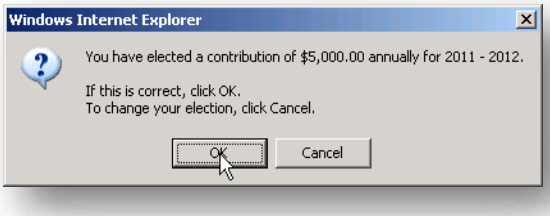
    b. Input a contribution value of up to $5,200 for the remainder of the plan year ending June 30.
    c. When all selections have been updated, click “Continue”.
    d. Click the “OK” button when the pop-up message to acknowledge your selection appears. To change your selection click “Cancel” and make the change then click “Continue” again.



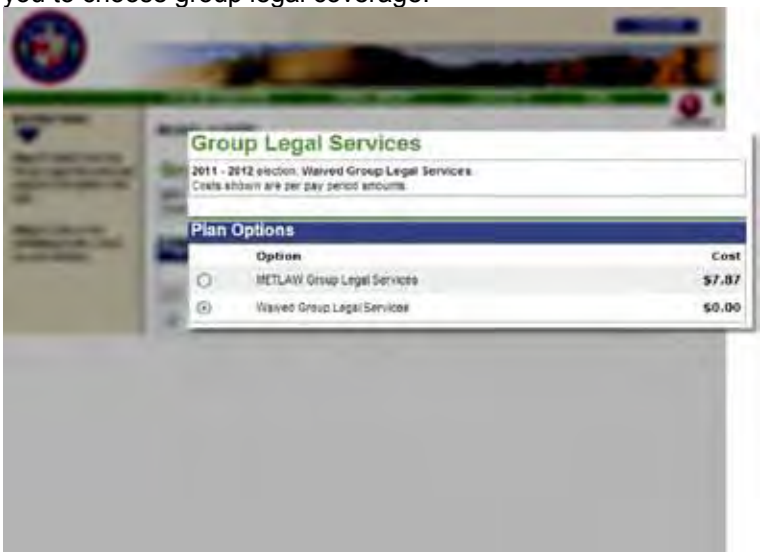
28. Dependent Care Flexible Spending Account
    a. This screen allows you to enroll in the Dependent Care Flexible Spending Account.



b. Input a contribution value of up to $5,000 for the remainder of the plan year ending June 30.
c. When all selections have been updated, click “Continue”.
d. Click the “OK” button when the pop-up message to acknowledge your selection appears. To change your selection click “Cancel” and make the change then click “Continue” again.

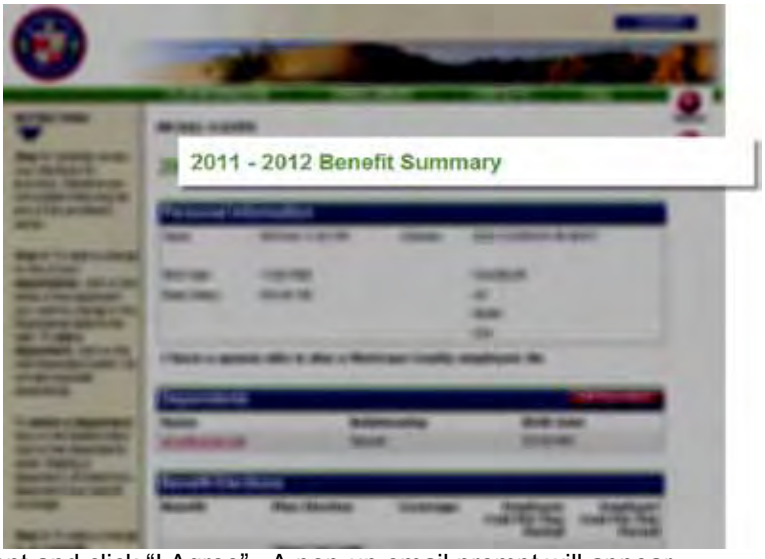


29. Group Legal
a. This screen allows you to choose group legal coverage.



b. When all selections have been updated, click “Continue”.
c. Click the “OK” button when the pop-up message to acknowledge your selection appears. To change your selection click “Cancel” and make the change then click “Continue” again.

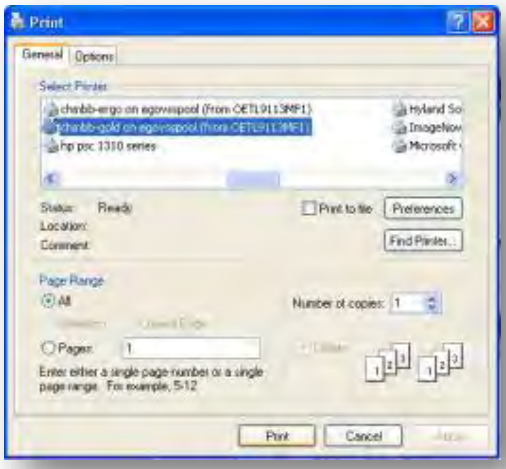
30. Once you have made all your benefit elections, a Benefit Summary will appear. Review the Benefit Summary and make any necessary corrections. If everything is correct, click “Submit” when finished.



31. Read Certification Statement and click “I Agree”. A pop-up email prompt will appear.

Input your email address and click “OK” to have a confirmation emailed to you. Otherwise click “Cancel”.

32. Click the “Print” button on the Confirmation Page to print the page to keep for your records.



33. The benefits enrollment process is complete. Click “Continue” and you will receive the “Thank You” message.

A Confirmation Statement will be mailed to your home address within 10 days. Compare the Confirmation Page you printed to the Confirmation Statement you receive in the mail. If the information on the Confirmation Statement does not match your printed Confirmation Page, contact the Employee Benefits Division within 10 business days at 602-506-1010 press 2 and then 2 again.

FY 2011-2012 Payroll Schedule
Used For Benefit Premium Calculations, Coverage Effective Dates & Coverage End Dates

	Beginning	Ending	Pay Day
1	June 27	July 10	July 20
2	July 11	July 24	August 3
3	July 25	August 7	August 17
4	August 8	August 21	August 31
5	August 22	September 4	September 14
6	September 5	September 18	September 28
7	September 19	October 2	October 12
8	October 3	October 16	October 26
9	October 17	October 30	November 9
10	October 31	November 13	November 23
11	November 14	November 27	December 7
12	November 28	December 11	December 21
13	December 12	December 25	January 4
14	December 26	January 8	January 18
15	January 9	January 22	February 1
16	January 23	February 5	February 15
17	February 6	February 19	February 29
18	February 20	March 4	March 14
19	March 5	March 18	March 28
20	March 19	April 1	April 11
21	April 2	April 15	April 25
22	April 16	April 29	May 9
23	April 30	May 13	May 23
24	May 14	May 27	June 6
25	May 28	June 10	June 20
26	June 11	June 24	July 3

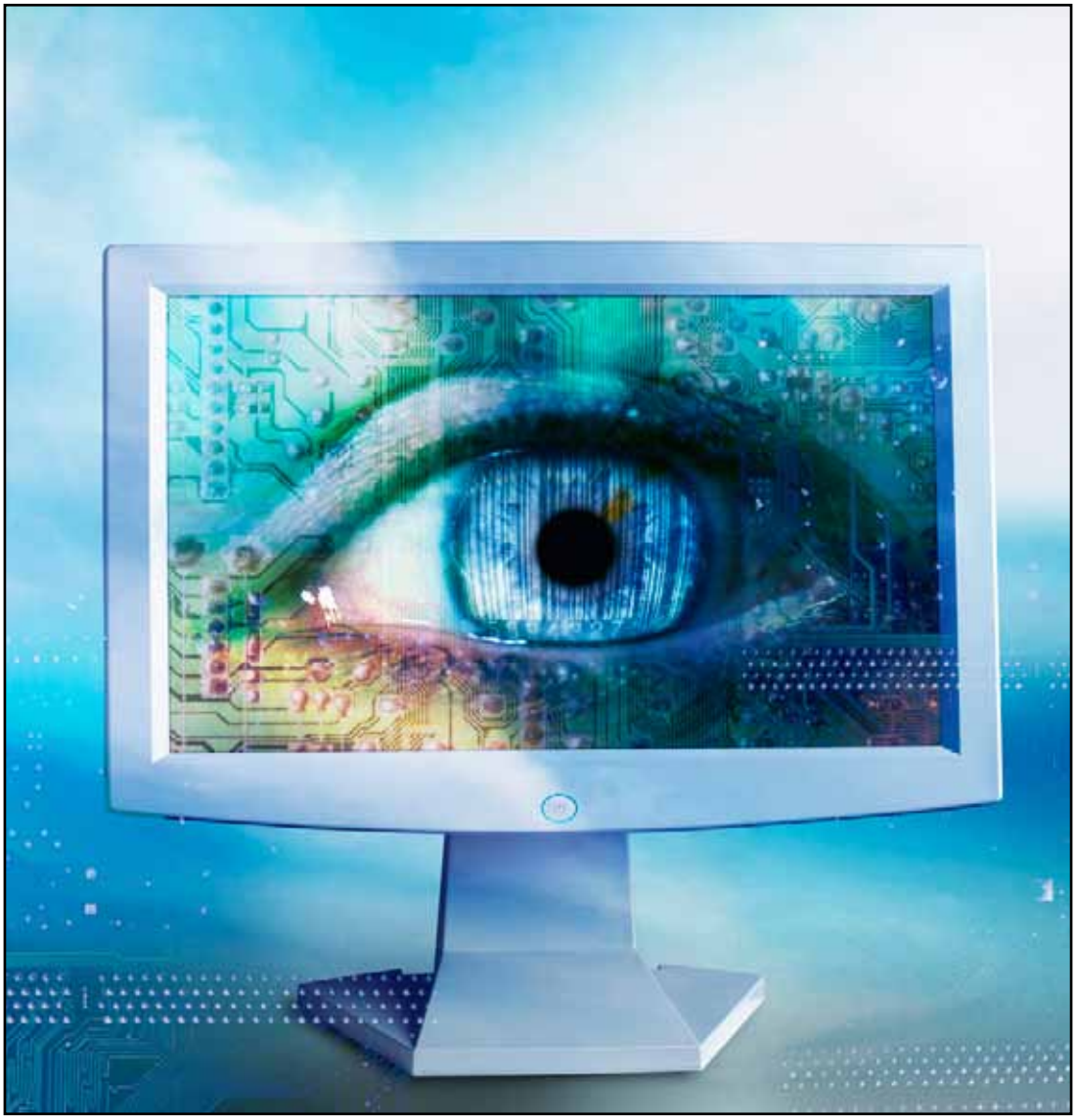
Holiday Schedule

	2011	2012
New Year's Day	Friday, December 31	Monday, January 2
Martin Luther King Jr./Civil Rights Day	Monday, January 17	Monday, January 16
President's Day	Monday, February 21	Monday, February 20
Memorial Day	Monday, May 30	Monday, May 20
Independence Day	Monday, July 4	Wednesday, July 4
Labor Day	Monday, September 5	Monday, September 3
Columbus Day	Monday, October 10	Monday, October 8
Veteran's Day	Friday, November 11	Monday, November 12
Thanksgiving Day	Thursday, November 24	Thursday, November 22
Christmas Day	Monday, December 26	Tuesday, December 25

Notifications

HIPAA Privacy Notice

In accordance with the privacy standards contained in the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Maricopa County, in its role as the administrator and/or sponsor of the Maricopa County Health Insurance Program, or in its role as the health plan makes available a notice setting forth its privacy practices through the EBC/Intranet **http://ebc.maricopa.gov/ehi** home page. This notice describes the potential uses and disclosures of Protected Health Information (PHI), the individual's rights and the plan's legal duties with respect to PHI. The privacy notice may be updated occasionally and such updates will be communicated through notices posted on the EBC.



Maricopa County's Group Health Plan
Notice of Privacy Practices

The Health Insurance Portability and Accountability Act, otherwise known as HIPAA, requires Maricopa County to protect the privacy of your personal health information, and to provide you with this notice. HIPAA is a federal law that was effective April 14, 2003. The reason the law requires Maricopa County to provide you with this notice is because certain benefit programs administered through the Employee Benefits Division are considered to be a Group Health Plan that is regulated by this law. This notice explains how your personal health information may be used, and what kind of rights you have under this law.

THIS INFORMATION DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Maricopa County offers a Group Health Plan (the "Plan"), which is a type of Health Plan, for eligible regular employees, certain contract employees, retirees, and COBRA participants.

The Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

- the Plan's uses and disclosures of your Protected Health Information (PHI);
- your rights with respect to your PHI;
- the Plan's duties with respect to your PHI;
- your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
- the person or office to contact for further information about the Plan's privacy practices.

The term "Protected Health Information" ("PHI") includes all individually identifiable health information transmitted or maintained by the Plan whether oral, written, or electronic.

Section 1. Notice of PHI Uses and Disclosures

Upon your request, the Plan is required to give you access to certain PHI in order to inspect and copy it. Use and disclosure of your PHI may be required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

Uses and Disclosures to Carry Out Treatment, Payment, and Health Care Operations

The entities that provide coverage under your medical, prescription, behavioral health and substance abuse, dental, vision, flexible spending accounts, and COBRA, may share your PHI for treatment purposes, to get paid for treatment, or to conduct health care operations. Many of these entities may provide you with their own Notice of Privacy Practices. Refer to Table A for a list of the current entities that provide the above coverage.

The Plan and/or its business associates may use your PHI, without your consent, authorization, or opportunity to agree or object, to carry out treatment, payment, and health care operations. For each business associate, the Plan has a written contract that contains terms to protect the privacy of your PHI.

The Plan may also share your information or allow the sharing of your PHI with Maricopa County as the Plan Sponsor for plan administration functions. The Plan Sponsor has amended its plan documents to protect your PHI as required by federal law.

Treatment is defined as the provision, coordination, or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers. In addition, providers may share information with each other. The Plan does not use PHI for treatment purposes.

Payment includes, but is not limited to, actions to make coverage determinations and payment (including billing, premium payment, recovery and collections, claims management, subrogation, reimbursements of overpayments, coordination of benefits, reviews for medical necessity and appropriateness of care and utilization review and pre-authorizations). For example, the Plan may tell a doctor (provider) whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations include, but are not limited to, quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating, and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. For example, the Plan may use information about your claims to determine compliance with physician-issued prescriptions, refer you to a disease or case management program, project future benefit costs or audit the accuracy of its claims processing functions.

Uses and Disclosures That Require Your Written Authorization

Your written authorization will be obtained before the Plan will use or disclose PHI for employer-related activities that include, but are not limited to, ombudsman activities which includes resolving your claims issue, fitness for duty examinations, short-term disability claims, return-to-work programs, employee assistance program, ergonomics evaluations, wellness programs, workers' compensations claims, and care received at an on-site medical clinic. You may revoke your authorization in writing, at anytime, to stop any future uses or disclosures.

Certain types of PHI, including PHI regarding communicable disease and HIV/AIDS, drug and alcohol abuse treatment, and evaluation and treatment for serious mental illness, may have additional protection under state or federal law. Your written authorization is required in order to release this type of information.

Uses and Disclosures That Require You Be Given an Opportunity to Agree or Disagree Prior To the Use or Release

Disclosure of your PHI to family members, other relatives, and your close friends is allowed if:

- the information is directly relevant to the family or friend's involvement with your care or payment for that care, and
- you either have agreed to the disclosure or have been given an opportunity to object and have not objected.

Uses and Disclosures for Which Consent, Authorization, or Opportunity to Object Is Not Required

Use and disclosure of your PHI is allowed without your consent, authorization, or request under the following circumstances:

1. When required by law.

2. When authorized by law regarding when you have been exposed to a communicable disease or are at risk of spreading a disease or condition.

3. When authorized by law to report information about abuse, neglect, or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice could cause a risk or serious harm. For purposes of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.

4. The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations, inspections, and licensure or for disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate health care fraud).

5. The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.

6. When required for law enforcement purposes (for example, to report certain types of wounds).

7. For law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.

8. When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

9. The Plan may use or disclose PHI for research, subject to conditions.

10. When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

11. When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization.

Section 2. Rights of Individuals

Right to Request Restrictions on PHI Uses and Disclosures

You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your request. The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Such requests should be made in writing to the **Employee Benefits Manager, 301 W. Jefferson St., Suite 3200, Phoenix, AZ 85003**.

Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI. *"Protected Health Information"* (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form. *"Designated Record Set"* includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the covered entity to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made in writing to the **Employee Benefits Manager, 301 W. Jefferson St., Suite 3200, Phoenix, AZ 85003**. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

Right to Amend PHI

If you believe your PHI is erroneous or incomplete, you have the right to request the Plan to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set. You must make this request in writing and provide a reason to support your request. The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI. Requests for amendment of PHI in a designated record set should be made in writing to the **Employee Benefits Manager, 301 W. Jefferson St., Suite 3200, Phoenix, AZ 85003**. You or your personal representative will be required to complete a form to request amendment of the PHI in your designated record set.

The Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request, but not before April 14, 2003. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) prior to the compliance date; or (4) based on your written authorization. If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Notice of Breach

If the Plan or one of its business associates acquires, accesses, uses or discloses your PHI in a manner not permitted by HIPAA that compromises the security or privacy of your PHI (a "breach"), the Plan is required to notify you. The notification shall be in writing and may include: (a) a description of what happened, (b) the dates of the breach and its discovery, (c) a description of the type of information involved, (d) steps you should take to protect yourself from harm that may result from the breach, (e) a description of what the Plan or its business associate is doing to investigate the breach, mitigate harm and protect against further breaches, and (f) contact procedures for you to ask questions or obtain additional information about the breach.

The Right to Receive a Paper copy of This Notice upon Request

To obtain a paper copy of this Notice, contact the **Employee Benefits Manager in writing at 301 W. Jefferson St., Suite 3200, Phoenix, AZ 85003**.

Section 3. The Plan's Duties

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of its legal duties and privacy practices. This is effective beginning April 14, 2003 and the Plan is required to comply with the terms of this notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this notice will be provided to all participants for whom the Plan still maintains PHI. The notice will be distributed electronically via the Electronic Business Center (EBC) Intranet and on the Employee Benefits Home page. Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individuals rights, the duties of the Plan or other privacy practices stated in this notice.

Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. However, the minimum necessary standard will not apply in the following situations:

- disclosures to or requests by a health care provider for treatment;
- uses or disclosures made to the individual;
- disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- uses or disclosures that are required by law; and
- uses or disclosures that are required for the Plan's compliance with legal regulations.

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual. With respect to information to which there is no reasonable basis to believe that the information can be used to identify an individual, such information is not individually identifiable health information.

In addition, the Plan may use or disclose "summary health information" to the plan sponsor or business associates for obtaining premium bids or modifying, amending or terminating the group health plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and from which identifying information has been deleted in accordance with HIPAA.

Section 4. Your Right to File a Complaint with the Plan or Department of Health and Human Services, Office for Civil Rights

If you believe that your privacy rights have been violated, you may complain to the Plan by writing to the Employee Benefits Manager, 301 W. Jefferson St., Suite 3200, Phoenix, AZ 85003. You may file a written complaint, either on paper or electronically, by mail, fax, or e-mail with the Secretary of the Department of Health and Human Services. To obtain a copy of the complaint form or for more information about the Privacy Rule or how to file a complaint with the Office for Civil Rights, contact any OCR office or go to www.hhs.gov/ocr/hipaa. Mailing address: Office for Civil Rights, U.S. Department of Health & Human Services, 90 7th Street, Suite 4-100, San Francisco, CA 94103, Voice Telephone (415) 437-8310, Fax (415) 437-8329, TDD (415) 437-8311. The Plan will not retaliate against you for filing a complaint.

Section 5. Whom to Contact at the Plan for More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the following individual: Employee Benefits Manager, 301 W. Jefferson St., Suite 3200, Phoenix, AZ 85003, telephone number (602) 506-1010, or via electronic mail BenefitsService@mail.maricopa.gov.

Section 6. Conclusion

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at *45 Code of Federal Regulations Parts 160 and 164*. This notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this notice and the regulations.

Table A

Entity	Description of Coverage	Entity	Description of Coverage
CIGNA HealthCare of AZ	Medical, Pharmacy, & Behavioral Health & Substance Abuse	Magellan Health Services	Behavioral Health & Substance Abuse
Walgreens Health Initiatives	Pharmacy	EyeMed Vision Care	Vision
CIGNA Dental	Dental	ADP	Health Care Flexible Spending Account
Delta Dental of AZ	Dental	ADP	COBRA
Employers Dental Services (EDS)	Dental		

Employee Acknowledgement

I hereby acknowledge receipt of this **Notice of Privacy Practices** and understand that is my responsibility to read the information contained herein.

Employee Name (printed) _____ Employee Signature _____ Date _____

Return your signed copy of this form to your Department HR Liaison

COBRA Initial Notification

Introduction

You are receiving this notice because you are currently covered under Maricopa County's Health Insurance Program (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

The Plan Administrator is Maricopa County Employee Benefits, located at 301 W. Jefferson St., Suite 3200, Phoenix, AZ 85003, and available via telephone by dialing 602-506-1010, press 2 and then 2 again to speak to a Representative or by emailing to **BenefitsService@mail.maricopa.gov**. The Plan Administrator is responsible for administering COBRA continuation coverage..

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage may be required to pay for COBRA continuation coverage. If you are required to pay for COBRA continuation coverage, you will be notified at the time you are offered COBRA continuation coverage of the amount and the date payment is due.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

1. Your hours of employment are reduced, or
2. Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

1. Your spouse dies;
2. Your spouse's hours of employment are reduced;
3. Your spouse's employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
5. You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

1. The parent-employee dies;
2. The parent-employee's hours of employment are reduced;

3. The parent-employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Maricopa County, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Continuation Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event (1) within 30 days of any of these events or (2) within 30 days following the date coverage ends.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. Generally Plans require that notification of such events be provided to the Plan Administrator within 60 days after the qualifying event has occurred. However, your Plan may allow a longer period of time to provide notification. Please consult your Plan's SPD to determine the Plan's qualifying event notification requirements. You must send this notice to: Maricopa County Employee Benefits and as directed under the terms of the Plan located in the SPD.

How is COBRA Continuation Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration (SSA) to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that you provide a copy of the SSA's disability determination to the Plan Administrator prior to the last day of the initial 18-month COBRA continuation coverage period **AND** within 60 days of the latest of the dates listed below:

- the date the qualified beneficiary was informed (through the Summary Plan Description (SPD) or Initial General Notice of COBRA Rights) of the responsibility and procedures for informing the plan of the disability determination;
- the date on which the qualifying event occurred;
- the date coverage was lost; or
- the date the SSA made their determination (date of the determination notice of award).

This notice should be sent to: Maricopa County Employee Benefits or other party as indicated in the COBRA Election Notice you receive at the time you are offered COBRA continuation coverage.*

Second qualifying event extension of 18-month period of continuation coverage

If, while receiving COBRA continuation coverage, your spouse and/or dependent child(ren) experiences another qualifying event which causes a loss of coverage, they can get additional months of COBRA continuation coverage, for a total of up to a maximum of 36 months from the date of the first qualifying event. This extension is available only to the spouse and dependent children if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to Maricopa County Employee Benefits or other party as indicated in the COBRA Election Notice you receive at the time you are offered COBRA continuation coverage.*

***Please note:** At the time you are being provided with this Initial General Notice of COBRA Rights, ADP Benefit Services is your employer's COBRA administrator. In the future, you should refer to the COBRA Election Notice you receive at the time you are offered COBRA continuation coverage to confirm that ADP Benefits Services still performs this function for your employer and that ADP Benefits Services remains the appropriate place for you to send notice of a Social Security Disability or Second Qualifying event.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Maricopa County Employee Benefits Division
301 W. Jefferson St., Suite 3200
Phoenix, Arizona 85003
Telephone number 602-506-1010
Fax number: 602-506-2354
Email: **BenefitsService@mail.maricopa.gov**

COBRA continuation coverage for the Plan is managed by:

ADP, Inc.
Telephone number 1-800-770-7981
https://www.benedirect.adp.com

The American Recovery and Reinvestment Act of 2009 (ARRA)

The American Recovery and Reinvestment Act of 2009 (ARRA) as amended by the Department of Defense Appropriations Act (2010 DOD Act) on December 19, 2009 and the Temporary Extension Act of 2010 (TEA) on March 2, 2010, provides for premium reductions for health benefits under COBRA. Eligible individuals pay 35 percent of their COBRA premiums; the remaining 65 percent is reimbursed to the coverage provider through a tax credit. The premium reduction applies to periods of health coverage that began on or after February 17, 2009 and lasts for up to 15 months.

To qualify, individuals must experience a COBRA qualifying event that is the involuntary termination of a covered employee's employment. The involuntary termination must generally occur during the period that began September 1, 2008 and ends on May 31, 2010. However, TEA also provides that an involuntary termination of employment is a qualifying event for purposes of ARRA if the involuntary termination:

- occurs on or after March 2, 2010 and no later than March 31, 2010; and
- follows a qualifying event that was a reduction of hours that occurred at any time from September 1, 2008 through March 31, 2010.

Income Limits

If an individual's modified adjusted gross income for the tax year in which the premium assistance is received exceeds $145,000 (or $290,000 for joint filers), then the amount of the premium reduction during the tax year must be repaid. For taxpayers with adjusted gross income between $125,000 and $145,000 (or $250,000 and $290,000 for joint filers), the amount of the premium reduction that must be repaid is reduced proportionately. Individuals may permanently waive the right to premium reduction but may not later obtain the premium reduction if their adjusted gross incomes end up below the limits. If you think that your income may exceed the amounts above, consult your tax preparer or contact the IRS at **www.irs.gov**.

Women's Health and Cancer Rights Act (WHCRA)

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call CIGNA Customer Service for more information.

Obtaining a Certificate of Creditable Coverage Under This Plan

Upon loss of coverage under this Plan, a Certificate of Creditable Coverage will be mailed to each terminating individual at the last address on file. You or your dependent may also request a Certificate of Creditable Coverage, without charge, at any time while enrolled in the Plan and for 24 months following termination of coverage. You may need this document as evidence of your prior coverage to reduce any pre-existing condition limitation period under another plan, to help you get special enrollment in another plan, or to obtain certain types of individual health coverage even if you have health problems. To obtain a Certificate of Creditable Coverage, contact CIGNA Customer Service. ADP also provides Certificates of Creditable Coverage and may also be contacted to request a replacement copy.

General Notice of the Plan's Pre-existing Condition Exclusion

The Open Access Plus In-Network plan, the Open Access Plus High and Low plans, and the Choice Fund Medical plan impose a pre-existing condition exclusion. This means that if you have a medical condition before coming to a Maricopa County-sponsored plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within 60 calendar days prior to your effective date of coverage. The pre-existing condition exclusion does not apply to pregnancy or to a child under age 19 (effective July 1, 2011).

This exclusion may last up to 12 months from your first day of coverage. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage".

- Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days.
- To reduce the 12-month exclusion period by your creditable coverage, you should give CIGNA a copy of any Certificates of Creditable Coverage you have.
- If you do not have a certificate, but you do have prior health coverage, you should contact your prior plan and ask them for a Certificate of Creditable Coverage. Please contact the EB Division at (602) 506-1010 if you need help demonstrating creditable coverage.

Notice of Special Enrollment Rights

In general, IRS restrictions prevent you from making changes to your coverage elections during the plan year. This means that once you make your health plan elections at Open Enrollment, you may not drop dependents or change your coverage until the next Open Enrollment period. You may be able to add or drop dependents during the plan year (but not change your plan coverage) if you experience and report a life event, also known as a qualified status change. These changes include the following:

- You get married or divorced.
- You acquire a dependent child through birth, adoption or placement for adoption.
- Your spouse or dependent dies.
- Your dependent no longer meets the plan's eligibility requirements.
- Your spouse terminates employment or begins new employment.
- You or your spouse change from part-time work to full-time work (or vice-versa).
- You or your spouse has a significant change in the cost of health care coverage.

- You are required to provide dependent medical coverage as a result of a valid court decree that meets the requirements of a Qualified Medical Child Support Order (QMCSO).
- You or your dependent's Medicaid or SCHIP coverage is terminated as a result of loss of eligibility. (An employee must be given at least 60 days after the date of termination of the coverage to request special enrollment.)
- You or your dependent becomes eligible for a state premium assistance subsidy under the plan from Medicaid or SCHIP. (An employee must be given a period of at least 60 days after the date on which eligibility for premium assistance has been determined to request special enrollment.)

Any benefit enrollment change you make must be consistent with your qualified status change. To change your coverage, you must complete the status change online through the Benefit Enrollment system via the ADP portal within 30 calendar days of the date you experience the status change. A request for the required documentation of your status change will be mailed to your home address. Your new elections will be effective on either the date of your status change or the date your status change was processed, and retroactive payroll deductions may be withheld. If you do not complete your status change online within the 30 calendar day period, you must wait until the next Open Enrollment period to change your benefits.

Certain status changes cannot be made through the Benefit Enrollment System, such as the events that allow a 60-day notification period. In these cases, a Group Insurance Status Change form must be completed and delivered to the EB Division within the 60-day period.

Medicare Secondary Payer Mandatory Insurer Reporting Requirements of Sect 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173 42 U.S.C. § 1395y(b)(7))

Requires the collection and reporting of the Social Security Number (or Medicare Health Insurance Claim Number "HICN") from active covered individuals. Active covered individuals are:

(1) employees and covered family members age 45 to 64,

(2) employees and covered spouses age 65 and older,

(3) employees and covered dependents who receive kidney dialysis or have had a kidney transplant, and

(4) any covered individual that the plan sponsor knows to be entitled to Medicare.

Genetic Information Nondiscrimination Act (GINA)

Under a new federal law, group health plans are prohibited from adjusting premiums or contribution amounts for a group on the basis of genetic information. A health plan is also prohibited from requiring an individual or his/her family member to undergo a genetic test, although the plan may request that a voluntary test be taken for research purposes.

The Heroes Earnings Assistance and Relief Tax Act (HEART)

HEART amended the Internal Revenue Code Section 125 to allow employers to provide qualified reservist distributions (QRDs) from health flexible spending accounts (FSAs) to employee-reservists who are called to active duty for 180 or more days, or for an indefinite period of time. A QRD is a distribution of all or a portion of the balance in an employee's account that is requested during the period that begins on the date of the call up and ends on the last date that the reimbursement could otherwise be made under the health FSA for the plan year. These distributions may be made after June 17, 2008.

Notice of Medicaid or Children's Health Insurance Program (CHIP) Offer of Free or Low-cost Health Coverage to Children and Families

If you are eligible for employment-based health coverage from Maricopa County, but are unable to afford the premiums, the State of Arizona may provide a premium assistance program that can help pay for coverage. The State may use funds from its Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Arizona's Medicaid (AHCCCS) or CHIP (KidsCare) programs, you can contact the State's Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid (AHCCCS) or CHIP (KidsCare), and you think you or any of your dependents might be eligible for either of these programs, you may contact the Arizona Medicaid or CHIP office at **http://www.azahcccs.gov/applicants/default.aspx**. You may also dial 1-877-KIDS-NOW or visit **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask if Arizona has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

You may be eligible for assistance paying your employer health plan premiums. Information is available at **www.AZAHCCCS.gov/applicants/default.aspx** or by calling 1-877-764-5437.

For more information on special enrollment rights, you can contact the following federal agencies:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

Mental Health Parity and Addiction Equity Act of 2008

Under a Federal law known as the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as amended ("HIPAA"), group health plans must generally comply with the requirement listed below. However, the law also permits local governmental employers that sponsor health plans to elect to exempt a plan from these requirements for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. Maricopa County has elected to exempt the Maricopa County Accident and Health Insurance Premium Plan (Second Amendment and Restatement) from the following requirement:

Parity in the application of certain limits to mental health benefits. Group health plans (of employers that employ more than 50 employees) that provide both medical and surgical benefits and mental health or substance use disorder benefits must ensure that financial requirements and treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applicable to substantially all medical and surgical benefits covered by the plan.

The exemption from these Federal requirements will be in effect starting July 1, 2010.

HIPAA also requires the Plan to provide covered employees and dependents with a "certificate of creditable

coverage" when they cease to be covered under the Plan. There is no exemption from this requirement. The certificate provides evidence that you were covered under this Plan, because if you can establish your prior coverage, you may be entitled to certain rights to reduce or eliminate a preexisting condition exclusion if you join another employer's health plan, or if you wish to purchase an individual health insurance policy.

Medicare Part D Creditable Coverage Notice

Background

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 requires group health plans that provide prescription drug coverage to disclose to individuals eligible for Medicare Part D whether the plan's coverage is "creditable," i.e., whether it is at least actuarially equivalent to the Medicare Part D coverage. Importantly, individuals who do not enroll in Medicare Part D when first eligible and who have gone 63 days or longer without creditable coverage generally will have to pay higher premiums permanently if they subsequently enroll. Thus individuals need to know the status of their coverage in order to make an informed decision about enrolling in Part D.

Notice

This notice applies to you if you are eligible for Medicare. Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Maricopa County and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Maricopa County has determined that the prescription drug coverage offered by the Employee and Retiree Benefit Plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide To Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Maricopa County coverage will not be affected. Your current coverage will be primary over the Medicare drug plan.

If you do decide to join a Medicare drug plan, you will not be able to drop your current Maricopa County

prescription coverage until the next Open Enrollment period. If you drop your current Maricopa County prescription coverage, you must also drop your medical and behavioral health coverage. Retirees who drop current Maricopa County coverage will not be allowed to re-enroll in the Maricopa County Retiree Benefit Plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Maricopa County and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For more information about this notice or your current prescription drug coverage, refer to the contact information located at the end of this notice.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Maricopa County changes. You also may request a copy of this notice at any time.

For more information about your options under medicare prescription drug coverage.

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Name of Entity/Sender:	Maricopa County Employee Benefits Division of the Business Strategies and Health Care Programs Department
Contact:	Employee Benefits
Address:	301 W. Jefferson St., Suite 3200, Phoenix, AZ 85003
Phone Number:	(602) 506-1010

WHO TO CONTACT

Maricopa County
Employee Benefits Division
Maricopa County Chambers Building
301 West Jefferson Street, Suite 3200
Phoenix, Arizona 85003-2145
Phone: (602) 506-1010
Fax: (602) 506-2354
TTY: (602) 506-1908
www.maricopa.gov/benefits
http://ebc.maricopa.gov/ehi
BenefitsService@mail.maricopa.gov

Maricopa County Wellness Works
Phone: (602) 506-3758 ~ Fax: (602) 506-1292

Medical Plans

CIGNA
Group #3205496
Customer Service
(800) 244-6224
Pre-Enrollment Questions
(800) 401-4041
24-Hour Health Information Line
(800) 564-8982
HSA Banking Unit Customer Service Line
(866) 524-2483
Healthy Pregnancies, Healthy Babies
(800) 615-2906
Healthy Rewards
(800) 870-3470
www.cigna.com
www.mycigna.com
www.mycignaplans.com
(username: maricopacounty2011 / password:cigna)
www.cigna.com/cmgaz

Pharmacy Plans

Catalyst Rx Pharmacy Plan
Group #512229
Member Services
(800) 207-2568
Prior Authorization
(877) 665-6609
Walgreens Mail Plan Services Member Service
(888) 265-1953
Mail Service Refills
(800) 797-3345
Specialty Pharmacy
(888) 782-8443
Medication Therapy Management
(866) 352-5310
Walgreens Onsite Pharmacy
(602) 283-9925
www.walgreenshealth.com

CIGNA Pharmacy Plan
(Choice Fund Medical Plan only)
Group #3205496
(800) 244-6224
CIGNA Home Delivery Service
(800) TEL-DRUG

EAP

Magellan Health Services
Group# N/A
(888) 213-5125
www.magellanhealth.com

Behavioral Health

Magellan Health Services
Group# N/A
(888) 213-5125
www.magellanhealth.com

CIGNA Behavioral Health
(Choice Fund Medical Plan only)
Group #3205496
(800) 244-6224
www.cignabehavioral.com

Vision

EyeMed Vision Care
Group #9750076 - Comprehensive Eye Exam
Group #9750092 - LASIK
Group #9750118 - Acute Care
Customer Service
(866) 723-0514
Pre-Enrollment Questions
(866) 299-1358
LASIK
(877) 5LASER6
www.eyemedvisioncare.com

Dental

Employers Dental Services
Group #11931 - Plan #300R
(602) 248-8912 or (800) 722-9772
www.mydentalplan.net

CIGNA Dental
Group #2465354
(888) 336-8258
www.mycigna.com

Delta Dental
Group #4500
(602) 938-3131 or (800) 352-6132
www.deltadentalaz.com

Life Insurance

The Standard
Policy# 645547
(888) 414-0396
www.standard.com/mybenefits/maricopa

Short-Term & Long-Term Disability

Sedgwick CMS
Group# 435000
Short Term Disability
(800) 599-7797
Long Term Disability
(800) 495-9301
www.sedgwickcms.com/calabasas

Retirement

Arizona State Retirement System
Phoenix - (602) 240-2000
Outside Phoenix - (800) 621-3778
www.azasrs.gov/web/index.do

Public Safety Retirement System
(602) 255-5575
www.psprs.com

Nationwide Retirement Solutions:
Deferred Compensation
(602) 266-2733
(800) 598-4457
www.maricopadc.com

Other

Automatic Data Processing, Inc. (ADP)
Flexible Spending Accounts
(800) 654-6695
Claims & Substantiation Fax
(866) 392-4090
Activate Debit Card
(877) 368-7517
www.flexdirect.adp.com

COBRA Administrator
(855) 219-5022
Call for applicable fax number
https://www.benedirect.adp.com
Initial enrollment forms:
ADP Benefits Services
PO Box 2968
Alpharetta, GA 30023-2968

Initial and ongoing payments:
ADP Benefit Services
PO Box 7247-0367
Philadelphia, PA 19170-0367

Maricopa County Dependent
Verification Service Center
ADP - DVS
PO Box 2338
Alpharetta, GA 30023-2338
(800) 847-8531 6AM - 6PM MT
Fax: (866) 400-1686

Liberty Mutual
Group #8871
Auto, Home and Renters Insurance
(800) 221-8135
www.libertymutual.com/lm/maricopacountyemployees

MetLaw® Hyatt Legal Plans
Plan 150 / Group #0518
(800) 821-6400
http://info.legalplans.com
(password - 1500518)

Biometric Screening Administrator
CIGNA Onsite
(800) 694-4982
https://www.cignascreenings.com/maricopa

Health Assessment Technical Assistance
(800) 853-2713
www.mycigna.com